

NEW PATIENT SCHEDULING DEMOGRAPHICS
ALL INFORMATION IS REQUIRED FOR SCHEDULING APPOINTMENTS. PLEASE COMPLETE ENTIRE FORM
SELECT ONE PREFERRED PCP BELOW:

Accepting New Patients Now:

Not Accepting New Patients At This Time:

Monticello - ___ Narain Mandhan, MD/ Crickett Engelbrecht, FNP-C
___ Glen Dust, MD / Cydney Longley, FNP
___ Lauren Fore, MD
___ Evelyn Huang, MD / David Liss, FNP

Brian Yocks, MD
Lauren Coovert, PA
Andrea Tirpak, APN, FNP-BC

Atwood ___ Tara Shutt, FNP-BC ___ Danielle Pare, NP

Cerro Gordo ___ Jamey Witmer, NP

LAST NAME _____ FIRST NAME _____ MIDDLE INIT _____

OTHER NAME KNOWN BY: _____

ADDRESS _____ PO BOX (IF APPLICABLE) _____

CITY _____ STATE _____ ZIP CODE _____

DOB _____ SS# _____

LANGUAGE SPOKEN _____ RACE _____ ETHNICITY _____ RELIGION _____

PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK

SECONDARY PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK

PREFERRED METHOD OF CONTACT:

- | | |
|-------------------------------|----------------------------------|
| <input type="checkbox"/> CALL | <input type="checkbox"/> EMAIL |
| <input type="checkbox"/> TEXT | <input type="checkbox"/> WRITTEN |

EMAIL _____

EMPLOYER _____

ADDRESS _____ PHONE _____

OCCUPATION _____ STATUS (FT, PT, PRN) _____

GUARANTOR (IF PATIENT IS UNDER 18) _____

ADDRESS _____

PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK ___ OTHER

DOB _____ SS# _____

CONTINUED ON BACK

INSURANCE-PRIMARY* _____ MEMBER ID # _____ GROUP # _____

***SUBSCRIBER INFORMATION (IF NOT PATIENT):**

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ADDRESS _____

SUBSCRIBER PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK ___ OTHER

SUBSCRIBER DOB _____ SUBSCRIBER SS# _____

INSURANCE-SECONDARY* _____ MEMBER ID # _____ GROUP # _____

***SUBSCRIBER INFORMATION (IF NOT PATIENT):**

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ADDRESS _____

SUBSCRIBER PHONE # _____ TYPE: ___ HOME ___ CELL ___ WORK ___ OTHER

SUBSCRIBER DOB _____ SUBSCRIBER SS# _____

CONTACT INFORMATION (OTHER THAN PATIENT):

PRIMARY CONTACT

LAST NAME _____

FIRST NAME _____

RELATIONSHIP _____

PHONE # _____

COMPLETE ADDRESS _____

SECONDARY CONTACT

LAST NAME _____

FIRST NAME _____

RELATIONSHIP _____

PHONE # _____

COMPLETE ADDRESS _____

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Mailing Address of Patient: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Last 4 digits of SSN: _____ MRN: _____

I authorize: Kirby Medical Group- Clinic Provider: _____ Kirby Medical Center - Hospital
 1000 Medical Center Dr., Monticello, IL 61856

To Release to: _____
 (Name of Health Care Facility, Individual, or Agency, etc.)

To Request from: _____ (Address)
 _____ (City, State, Zip) _____ (Phone) _____ (Fax)

Method of Release: Mail Pick up in Person at: HIM Department Emergency Dept. Registration Fax to 217-762-1702
 E-mail Service Provided by ScanSTAT E-mail Address: _____

SPECIFIC RECORDS TO BE RELEASED:

Clinic	Hospital
Dates: _____ to _____	Dates: _____ to _____
<input type="checkbox"/> Record Abstract (last 2 years) <input type="checkbox"/> Immunization Record <input type="checkbox"/> Mental Health (requires additional authorization form) <input type="checkbox"/> Other _____ <input type="checkbox"/> Provider Notes	<input type="checkbox"/> ED Visit(s) <input type="checkbox"/> Immunization Record <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> Pathology <input type="checkbox"/> Radiology <input type="checkbox"/> Reports <input type="checkbox"/> CD Images <input type="checkbox"/> Inpatient Hospitalization <input type="checkbox"/> Abstract – H&P, Disc Sum, Progress Notes <input type="checkbox"/> Complete Stay <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Therapy Services <input type="checkbox"/> Other _____

I specifically authorize the release of information relating to:

Substance abuse (including alcohol/drug abuse treatment) HIV-related information (HIV/AIDS-related testing) & communicable disease(s) information

Genetic Information Child Abuse/Neglect Abuse of Adult with a Disability Sexual Assault Treatment

X _____
 SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ DATE

The purpose of this disclosure of information is _____ continuing care
 (i.e., continuing care, insurance claim, legal counsel, etc.)

A separate special authorization must be completed to release mental health records.

- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
- I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following date or event: _____ . If I do not specify an expiration date or event, this authorization will expire in one year.
- I understand that I am entitled to a copy of this authorization.
- I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
 Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney)
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: Parent Legal Guardian

Signature: X _____ Date Signed: _____

Printed Name of Person Signing (if not patient): _____ Phone#: _____

STAFF USE ONLY

Verbal Authorization Given By: _____ Verbal Obtained by Staff Name: _____ Reason for Verbal: PHE Other: _____
Name Relationship to Patient

Records Given to Patient by Staff Name: _____ Type of ID Verified _____ Date: _____
 HIM Registration Clinic

**THIS PAGE LEFT
INTENTIONALLY
BLANK**

HEALTH HISTORY QUESTIONNAIRE

Pediatric 0 - 11

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (Last, First, M.I.): _____	DOB: _____
Birth Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	
Previous or referring doctor: _____	Date of last physical exam: _____
Language spoken at home: _____	

PERSONAL HEALTH HISTORY

Up to date with childhood vaccines? Yes No Why? _____

Immunizations and dates (if known):

COVID

HPV

Influenza

List any medical problems that other doctors have diagnosed:

ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/Other <input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Delay <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Lead Poisoning <input type="checkbox"/> Yes <input type="checkbox"/> No	Strep Throat (recurrent) <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No	UTI <input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Delay <input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No	Varicella (chickenpox) <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No	Otitis Media <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____
Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No		_____

Birth History: Please complete for patients currently under 1 year of age.

Birth Length: _____	Birth Weight: _____	Birth Head Circ: _____
Discharge Weight: _____	Gestational Age: _____	Delivery Method: Vaginal / C-section
Duration of Labor: _____	Hospital Name: _____	
APGAR Score (1 min): _____	APGAR Score (5 min): _____	Feeding: Breast / Formula

Next Page

Surgeries		
------------------	--	--

Year	Reason	Hospital

Other hospitalizations		
-------------------------------	--	--

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
----------------------------------------------------------------------------------------------	--	--

Name of Drug	Strength	Frequency Taken

Allergies to Medications	
---------------------------------	--

Name of Drug	Reaction You Had

[Previous Page](#)

[Next Page](#)

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE
OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Diet	Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat on an average day?
	Rank salt intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank fat intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank sugar intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	<input type="checkbox"/> Juice <input type="checkbox"/> Tea <input type="checkbox"/> Cola # of cups/cans per day?
Dental Hygiene	<input type="checkbox"/> Been to dentist <input type="checkbox"/> Brush teeth regularly Last appt: _____
Secondhand Smoke Exposure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Safety & Environmental Exposures	Exposure to Tobacco Smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No Who smokes: _____ Smoke Exposure Location: <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Both Pets: <input type="checkbox"/> Yes <input type="checkbox"/> No Guns in the House: <input type="checkbox"/> Yes <input type="checkbox"/> No Mold/Mildew: <input type="checkbox"/> Yes <input type="checkbox"/> No Carpets: <input type="checkbox"/> Yes <input type="checkbox"/> No Lead Paint: <input type="checkbox"/> Yes <input type="checkbox"/> No Pests/Rodents: <input type="checkbox"/> Yes <input type="checkbox"/> No
Day Care Education Employment	Type of Day Care (check all that apply): <input type="checkbox"/> Family Member/Relative/Friend <input type="checkbox"/> Child Care Center (commercial) <input type="checkbox"/> Prekindergarten <input type="checkbox"/> Head Start <input type="checkbox"/> Preschool <input type="checkbox"/> Early Intervention <input type="checkbox"/> Home Child Care Provider (day care in someone's home)

[Previous Page](#)

[Next Page](#)

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Grandmother <i>Maternal</i>		
Mother			Grandmother <i>Paternal</i>		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F				

Do you have any concerns about mental health? Yes No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy Levels
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Previous Page

Next Page

HEALTH GOALS

Please list your top health goals and any factors preventing you from achieving those goals.

<input type="checkbox"/> Goal:	<input type="checkbox"/> Preventing Factors:
<input type="checkbox"/> Goal:	<input type="checkbox"/> Preventing Factors:
<input type="checkbox"/> Goal:	<input type="checkbox"/> Preventing Factors:

Dear Patient,

We at Kirby Medical Group want to ensure we are fully successful in providing the care you deserve, in the setting which is most appropriate, while being financially responsible as a Medical Home. Please take a few minutes to answer the following questions and complete the checklist so that we can help guarantee that success. We are dedicated to our patients and want to help you reach your healthcare goals. Thank you for choosing Kirby Medical Group as your Patient-Centered Medical Home.

How often do you seek care in an Emergency Department?	<input type="checkbox"/> Less than once a year	<input type="checkbox"/> 2-3 times a year	<input type="checkbox"/> 3-5 times a year	<input type="checkbox"/> More frequently than 5 times a year
How often are you hospitalized for chronic illness? Leave blank if not applicable.	<input type="checkbox"/> Less than once a year	<input type="checkbox"/> 2-3 times a year	<input type="checkbox"/> 3-5 times a year	<input type="checkbox"/> More frequently than 5 times a year
Do you see any specialists for any diseases or chronic illnesses?	<input type="checkbox"/> Yes, please list:			
How many medications do you take on a daily basis:	<input type="checkbox"/> 0-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 5-7	<input type="checkbox"/> More than 7
Do you use any social or community services to help you meet your healthcare needs? Leave blank if not applicable.	<input type="checkbox"/> Yes, please list:			

Previous Page

Next Page

NEW PATIENT CHECKLIST

- I have completed the Release of Records form or I have retrieved my health records and submitted to Kirby Medical Group. These include any screening records (colonoscopies, mammograms, lab work), vaccination records (if the patient is a child), medication lists, pharmacy records, surgical history, specialist visits (cardiology, pulmonology, rheumatology, etc.), or other pertinent history.
- I actively participated in choosing my provider at Kirby Medical Group, a provider was not assigned to me.
- I have submitted my up-to-date insurance information. If you do not have insurance, please see someone at the desk to obtain information on how we can help you find an insurance payor.
- I have been given information on Kirby Medical Group's No-Show and Appointment Cancellation Policies.
- I have been given information on Solution Reach, Kirby Medical Group's automated appointment reminder service and electronic communication portal.
- I have received a copy of information on the services we provide at each Kirby Medical Group location and services available at Kirby Medical Center.

Patient Signature

Date

Thank you for taking the time to complete this information. If you have any questions, please see the front desk or you may contact Kirby Medical Group's clinic director, Sara Wells, at (217) 762-1701.

Previous Page

Save

Complete

NEW PATIENT INTAKE PEDIATRIC

KMG 50 Rev. 10/2023 Pg 6 of 6