**Today's Date** _____

# KERNODLE CLINIC FAMILY PRACTICE – ELON
## 908 S. Williamson Ave.
## Elon, NC 27244

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Social Security Number: _____-_____-_____ E-mail address _____

Address: _____ Telephone:

_____ Home: (  ) _____-_____

_____ Work: (  ) _____-_____

Employer: _____

Name and address of person responsible for payment of account: _____

_____

_____

Relative (in case of emergency): _____ Relationship: _____

Relative's Address: _____ Telephone:

_____ (  ) _____-_____

Do you have a living will? Y N Are you an organ donor? Y N

## PAST MEDICAL HISTORY

Circle any of the following medical conditions you have ever had:

| | | | |
|---|---|---|---|
| Allergies or Asthma | Depression | Hemorrhoids | Osteoporosis |
| Alcoholism | Diabetes | Hepatitis (Jaundice) | Phlebitis |
| Anemia | Drug Abuse | Hernia | Pleurisy |
| Arthritis | Eczema – Hives | High Blood Pressure | Psoriasis |
| Breast Lumps/Cysts | Epilepsy or Seizures | Kidney Stones | Stroke |
| Cancer (Tumor) | Glaucoma | Liver Disease | Suicide Attempt |
| Cataracts | Gout | Lung Disease | Thyroid Disease |
| Chicken Pox/Shingles | Heart Attack | Menstrual Problems | Ulcer |
| Congestive Heart | Heart Blockage | Migraines | Venereal Disease |

Other: _____

**List any Hospitalizations or Surgeries and the year they occurred:**

_____ _____

_____ _____

**Medications:** [List all you take and its dose (strength and how often you take it)]

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**REACTION TO MEDICATION:** (List medication name and reaction to medication)

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**IMMUNIZATIONS:** Tetanus (within 7 years) Y / N Pneumovax (Date): _____

**SOCIAL HISTORY:**

Are you (circle one): Married Single Divorced Widowed
Children? Y N Ages? _____
Occupation: _____ (list last if retired)
Use Tobacco? Type _____ How much per day? _____ (packs/cans)
Use Alcohol? Type _____ Amount per day? _____ Weekends? _____
Do you use any other drugs/marijuana? Yes / No Type: _____
Do you exercise? Y N Number of times per week? _____ Minutes each time? _____
How many times per week do you eat: red meat _____; fast foods _____; fried foods _____

**FEMALE PATIENTS ONLY:**

How many total times pregnant? _____ How many babies? _____ Miscarriages/Abortions? _____
Date of last menstrual period: _____ Are your periods regular? Y N
When was your last PAP smear? _____ Has it ever been abnormal? Y N
When was your last mammogram? _____ Has it ever been abnormal? Y N
Have you ever experienced urinary incontinence (leaking of urine)? Y N

*{Please see the following pages..}*

**Review of Systems**

Within the last 6 months have you had problems with your:

| | Yes | No | Please Describe |
|---|---|---|---|
| General fatigue, weight loss, etc.) | | | |
| Eyes (blurriness, burning, vision, etc.) | | | |
| Ears, Nose, Throat (drainage, bleeding, hard to swallow, etc.) | | | |
| Lungs or Breathing (shortness of breath, cough, wheeze, etc.) | | | |
| Heart (chest pains, murmur, skipping, etc.) | | | |
| Digestion (heartburn, constipation, etc.) | | | |
| Urinary system (leaking, frequency, burning, or pain, etc.) | | | |
| Bones/Joints (swelling, stiffness, pain, etc.) | | | |
| Skin (rashes, ulcers, etc.) | | | |
| Nerves (headache, dizziness, passing out, tremor, memory, etc.) | | | |
| Depression, feeling uptight, sleep problems | | | |
| Glands (problems with heat/cold, urine, eating, dry skin, hair change) | | | |

**Family History:** (Put an "X" in the box if anyone has had, and age at diagnosis.)

| | Father | Mother | Father's Parents | Mother's Parents | Siblings |
|---|---|---|---|---|---|
| Heart Attack (<age 60) | | | | | |
| Hypertension | | | | | |
| Stroke | | | | | |
| Cancer : | | | | | |
| Breast | | | | | |
| Colon | | | | | |
| Prostate | | | | | |
| Other (list type) | | | | | |
| Diabetes | | | | | |
| Asthma/Allergies | | | | | |
| Mental Illness | | | | | |
| Bleeding Problem | | | | | |
| Epilepsy or Convulsions | | | | | |
| Osteoporosis | | | | | |
| Other | | | | | |

*{Please see the following pages..}*

# ACCESS PERMISSION FORM

*PROTECTED HEALTH INFORMATION*

Please indicate below any persons that are permitted to have access to your protected medical information (e.g., lab results, medical records, x-ray reports, billing records, etc.).

Also, please note any exceptions to medical information that can be released (For example, "Do not release information about lab tests.").

☐ I do not wish to list any individuals.

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____

_____ _____ _____

**Signature:** Patient/Personal Representative Date Expire Date

_____ _____

Patient Social Security Number Patient Date of Birth

_____ _____

Name of Personal Representative Relation to Patient or Authority to Act

Last Name _____ First Name _____ Acct No_____

## Notice of Privacy Practices

I understand that my protected health information will be kept private and confidential in accordance with Kernodle Clinic's privacy practices. Kernodle Clinic has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. My signature below indicates that I have been given the chance to review a current copy of Kernodle Clinic's "Notice of Privacy Practices".

## Financial Responsibility

I understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance coverage or have not provided current or accurate insurance information, I am responsible for payment of all charges. I understand that any balances that become past due may be referred to a collection agency. If I have overpaid a balance due on any individual Kernodle Clinic provider, I agree that this overpayment may be transferred to pay on a balance due for another Kernodle Clinic provider.

## Assignment of Insurance Benefits

I hereby assign, transfer, and convey all my rights, title, and interest to medical reimbursement under my insurance policy(s) to Kernodle Clinic, Inc. for professional services rendered in the course of any examination or treatment. This authorization shall remain valid until revoked by me in writing. It is understood, whether I sign as agent, patient, or as guarantor, that I am directly responsible and will pay for services rendered and not covered by my health insurance.

Date: _____ Signature*: _____

***If signed by authorized representative, print name of representative and describe relationship with patient or authority to sign on behalf of patient:***

Representative: _____

Relationship or Authority: _____

**Patient refused or was unable to sign but was given a copy of the Kernodle Clinic "Notice of Privacy Practices" on _____ (*date and time*).**
**Patient refused or was unable to sign for the following reason(s):**
**_____.**
**Staff signature: _____ Date: _____ Time: _____ am/pm**

**Kernodle Clinic, Inc.** **Revised April, 2012**

## Authorization for Release of Health Information

Patient Name _____ Date of Birth_____ Phone: _____

Address _____ City _____ State ____ Zip _____

The patient or patient's representative signature will indicate you have read and agree with the following statements. **Please read the following carefully:**

I understand that the information disclosed as a result of this authorization may be re-disclosed; and, once disclosed to a third party, my information may no longer be protected by privacy regulations.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Kernodle Clinic, except that:

a. if this authorization is for research (clinical trials) purposes, then Kernodle Clinic may refuse to allow me to participate in the research study, and

b. if the purpose of this authorization is to share the results of pre-employment or employment screening tests with my prospective or current employer, then Kernodle Clinic may refuse to provide such testing.

I understand that I may revoke this authorization at any time by notifying Kernodle Clinic in writing. The procedure for revoking this authorization is set forth in the Kernodle Clinic Notice of Privacy Practices.

Unless revoked earlier, this authorization expires on _____ (*date or event that triggers expiration*). If I fail to specify an expiration date or event, this authorization will expire automatically one (1) year from date of signature.

**I hereby authorize _____(PROVIDER) the use and/or disclosure of my health information as described below.**

Please send the following information: **(Please check all items that apply)**

____ All information in my record from _____(date) to _____(date).

If not all information, please select the information to be disclosed and the dates of service:

____ Office notes; ____ Lab results; ____Pathology reports; ____ X-ray reports; ____ Other_____

Please indicate by your initials if you want the following information excluded from disclosure:

_____ Mental health; _____ Drugs/Alcohol; _____ HIV/AIDS; _____Genetic testing

**Please send this information to the following recipient: (Must be completed for records to be sent)**

_____ Kernodle Clinic
908 S. Williamson Avenue
Elon, NC 27244

OR _____

_____

_____

Telephone: _____

Fax:

**Purpose of Disclosure**:

___Referral to physician ___Personal use ___Insurance
___Attorney/legal ___Social services/disability ___Workers Comp

I have read and understand the information in this authorization. I certify that I have received a copy of this authorization.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's rep Relationship to patient or authority to act