KERNODLE CLINIC – INTERNAL MEDICINE

1234 Huffman Mill Rd., Burlington, NC 27215 336-538-2360

New Patient Medical History - Please complete this two-sided form prior to your first appointment

Name: ______________________ Date of Birth: ___/___/___ Age: ____ Sex: ____

Address: ____
Street City State Zip Code

Telephone: (Home) ______________ (Work) ______________ Occupation: ______________

Do you have a living will? ___Yes ___No (If yes is copy on file? ____) Are you an organ donor? ___Yes ___No

Relative: ______________________ Telephone: ______________________
In case of emergency

Address: ____
Street City State Zip Code

♦ Please briefly state in the box below the reason for your visit ♦

Reason for Visit:

Personal Physician:

Referred by:

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
☐ Hypertension		☐ Cancer – Type _______	
☐ High Cholesterol		☐ Migraines	
☐ Hypo/Hyperthyroidism		☐ Anemia	
☐ COPD, Emphysema or Asthma		☐ Kidney stones	
☐ Diabetes		☐ Ulcers/stomach issues	
☐ GERD		☐ Epilepsy/Seizures	
☐ Depression or Anxiety			
☐ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Drug or Food Allergies ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Number of children: Age(s):	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?		
On average, how much did you smoke per day?		
Do you have caffeine?	How much per day?	

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				
Adopted: Yes / No				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Kernodle Clinic

A DukeMedicine PRACTICE

Financial Policy

Kernodle Clinic values the trust our patients place in us and we want to help our patients meet their health goals. We also want our patients to be informed about their financial obligations for our services.

1. <u>UNINSURED/SELF PAY</u>
   Patients without health insurance are expected to pay a $100 deposit on the day of their appointment.

2. <u>DEDUCTIBLE/CO-INSURANCE</u>
   We will file claims to the patient's insurance company. Patients are expected to pay up to a $100 deposit on the day of their appointment towards their unmet deductible or co-insurance. If a patient provides proof their deductible and maximum out of pocket has been met for the year, then a deposit will not be required.

3. <u>PAST DUE BALANCES</u>
   Patients are responsible for timely payment of their account balances. Failure to make timely payments on these balances may prevent patients from receiving future appointments. Should patients need to make payment arrangements or questions about their bill, they can call our billing office at 1-800-782-6945.

   Patients who have had a recent visit to the hospital emergency department and need a physician evaluation as a follow-up to that visit are expected to pay for the services Kernodle provides as indicated above.

4. <u>NO SHOW FEES</u>
   Patients will be charged a "no-show" fee if they fail to cancel their appointment at least 24 hours in advance. Three or more missed appointments may result in your being dismissed from Kernodle Clinic.

   As a *courtesy*, our office attempts to remind patients of their appointments at least two days in advance in order for them to have adequate notice to cancel if necessary; however, the patient is ultimately responsible for keeping a record of their appointments.

   If there are extenuating circumstances and you are unable to notify us 24 hours in advance, you may contact a supervisor at 336-538-1234 to request a one-time only waiver. Please note, you will be charged a "no-show" fee for future missed appointments without having canceled 24 hours in advance.

NO SHOW FEES: Office Visit = $25.00 Annual Physical / Procedure Visit = $50.00

I have read and understood the above stated financial policies 1 - 4. I agree to accept.

Signature:____ Date:____________

Parent/Legal Guardian Signature:____________________________ Date:____________