Patient Name _____ Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Phone _____

City _____ State _____ Zip Code _____

Sex M F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Phone _____
(if different from patient's)

City _____ State _____ Zip Code _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to patient _____ Birthdate _____

Address _____ Phone _____
(if different from patient's)

City _____ State _____ Zip Code _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

ASSIGNMENT and RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information and necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Patient Name _____ Date _____

MEDICAL HISTORY

Your problem today _____

_____

_____

Other Medical Problems _____

_____

Childhood Illnesses _____

_____

Previous Surgeries

- ☐ I have not had any surgery
- ☐ Appendectomy
- ☐ Gall Bladder
- ☐ Other Surgery _____
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Cardiac Bypass
- ☐ Balloon Angioplasty
- ☐ Tubal Ligation/Sterilization
- ☐ Hysterectomy

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes How many packs per day? _____ When did you start? _____

Do you drink? ☐ No ☐ Yes How many drinks per day? _____ When did you start? _____

Do you follow a special diet? ☐ No ☐ Yes _____

Do you exercise? ☐ No ☐ Yes _____

What type of work do you do? _____

Hobbies _____

FAMILY HISTORY (heart disease, cancer, diabetes)

Father _____

Mother _____

Other _____

Allergies ☐ None

_____

_____

_____

Current Medications ☐ None

_____

_____

_____

Patient Name _____ Date _____

VACCINATIONS (date)

- ☐ COVID19 Vax _____
- ☐ Flu Shot _____
- ☐ Hep A _____
- ☐ Hep B _____
- ☐ Shingles _____
- ☐ Pneumovax _____
- ☐ X-rays _____
- ☐ Tetanus _____
- ☐ Other: _____

DIAGNOSTIC STUDIES

- ☐ EKG _____
- ☐ X-rays _____
- ☐ Mammogram _____
- ☐ PAP Smear _____
- ☐ Colonoscopy (Colon Check _____
- ☐ Cholesterol Check _____
- ☐ Other _____

REVIEW OF SYSTEMS (details)

- ☐ Recent infections _____
- ☐ Fever _____
- ☐ Chills _____
- ☐ Weight change _____
- ☐ Night Sweats _____
- ☐ Energy Level _____
- ☐ Diabetes _____
- ☐ Breathing Disorder _____
- ☐ Cough _____
- ☐ Shortness of Breath _____
- ☐ Wheezing _____
- ☐ High Blood Pressure _____
- ☐ Heart disease _____
- ☐ Irregular Heartbeat _____
- ☐ Chest Pain _____
- ☐ Stomach Ulcer _____
- ☐ Heartburn _____
- ☐ Stomach Pain _____
- ☐ How is your appetite? _____
- ☐ Nausea _____
- ☐ Vomiting _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Allergy symptoms _____
- ☐ Arthritis _____
- ☐ Fractures _____
- ☐ Bone or Joint pain _____
- ☐ Swelling of joints or ankles _____
- ☐ Prostate Problems _____
- ☐ Problems Passing your Urine _____
- ☐ Getting up at night to urinate _____
- ☐ Skin rash or other skin problems _____
- ☐ Abnormal Bleeding or Brusing _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Dizziness _____
- ☐ Headaches _____
- ☐ Weakness to any part of your body _____
- ☐ Problems walking _____
- ☐ Visual Problems _____
- ☐ Hearing Problems _____
- ☐ Anxiety _____
- ☐ Depression _____
- ☐ Use Recreational Drugs _____

DEMOGRAPHIC UPDATE

Last Name	First Name		Middle Name
Social Security Number	Age	Date of Birth	
Mailing Address		Apt No	
City / State		Zip	Phone #

By providing the phone number(s) below, you agree that T & K and companies working for T & K may confidentially contact you and/or leave a message. Messages may include communications that are pre-recorded and automatically dialed, however these calls will never include advertisements or marketing. If you provide your email address or cell number, we will send you general updates and appointment reminders via email or text message. These updates will not include specific information about your treatment or diagnosis. These general updates and reminders will not be encrypted. You may unsubscribe at any time.

Primary Insurance Name	ID#	Group #	POLICY HOLDER NAME/DOB/RELATIONSHIP
Secondary Insurance Name	ID#	Group #	POLICY HOLDER NAME/DOB/RELATIONSHIP

RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

I hereby authorize T & K to release any medical or other information needed to process all insurance claims. I authorize payment of insurance benefits directly to T & K. I agree that I am responsible for payments for services rendered, deductibles and coinsurance. I am aware that failure to pay may result in termination of the patient / clinic relationship. A photocopy of this authorization shall be considered as valid as the original. This authorization will remain in effect until revoked by me in writing.

By signing this form, I am saying that I understand what is written above and that I voluntarily ask for and consent to treatment.

Patient or Authorized Signature	*Date*

Please provide your email address if you would like to participate in our patient portal:

_____

Release of Information

T & K Physician Associates, LLC is authorized to release any test results and/or medical information to the following:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Phone #: _____ **Phone #:** _____

Emergency Contact:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Phone #: _____ **Phone #:** _____

Patient Name_____ Date _____

Acknowlegment & Review of Notice of Privacy Practices

I have reviewed T&K Physician Associates, LLC Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority