Kirk & Kirk Health Clinic, P.C. 01/2012

1539 West Andrew Johnson Hwy,
Morristown, TN 37814
423-585-5556

CONFIDENTIAL PATIENT DATA **Today's Date:** _____

Last Name:_____First:_____Middle:_____

Nick Name:_____ ❑ Male ❑ Female Date of Birth:_____

Social Security #:_____ Ethnicity: _____

Race:_____ Age: _____ Primary Language: _____

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Widowed

Address: _____
City: _____ State: _____ Zip+4 digits: _____

Home #:_____Work #:_____Ext #:_____ Cell #: _____

If we need to contact you please indicate which # you prefer we call… ❑ home ❑ cell ❑ work

Job Title _____ Are you a full time student?_____

Your Employer & Address:_____
_____

Name of Spouse or Nearest Relative: _____ Phone:_____

Referred by: ❑Family: Name_____ Relation_____
❑ Mail ❑ Friend ❑Yellow Pages ❑Other_____

Payment for Services will be by: ❑Cash/Check/Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.:_____

Insured's Employer:_____ Employer's Phone #:_____

Date of Birth of Insured:_____ Insured's Social Security #:_____

Do you have a secondary insurance? ❑No ❑Yes Name: _____

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	indigestion	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	venereal disease	❑	❑	❑	muscular dystrophy	❑	❑	❑	cancer

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition_____ Date of Last Physical Exam_____
SURGICAL HISTORY:
1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No Have you ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY : ❑Job ❑Auto ❑Other 1. _____Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: ****** Rate Your Symptoms 1-10**
(1 being least serious)

1._____ _____
2._____ _____
3._____ _____
4._____ _____

SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT

SYMPTOMS DEVELOPED FROM: ❑ JOB RELATED INJURY ❑ AUTO ACCIDENT ❑ ACCIDENT
❑ UNKNOWN CAUSE ❑ ILLNESS ❑ OTHER

DATE OCCURRED? _____

HOW OCCURRED? _____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑ sharp ❑ nagging ❑ burning ❑ dull
❑ shock like ❑ numb ❑ come & go ❑ are constant

IS YOUR PAIN: ❑ local **OR DOES YOUR PAIN:** ❑ travel to other areas

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑ BENDING ❑ REACHING ❑ COUGHING ❑ SNEEZING ❑ SITTING ❑ STANDING
❑ TURNING HEAD ❑ LIFTING ❑ WALKING ❑ LYING DOWN ❑ STRAINING AT STOOL

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑ BENDING ❑ SITTING ❑ LIFTING ❑ STANDING
❑ LYING DOWN ❑ REACHING ❑ WALKING ❑ TURNING HEAD

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

❑blurred vision	❑ buzzing in ears	❑cold feet	❑cold hands	❑concentration loss/confusion
❑cold sweats	❑constipation	❑diarrhea	❑dizziness	❑depression /weeping spells
❑fever	❑face flushed	❑fainting	❑fatigue	❑light bothers eyes
❑headaches	❑insomnia	❑loss of balance		❑head seems too heavy
❑loss of smell	❑loss of taste	❑low resistance to colds		❑muscle jerking
❑stiff neck	❑stomach upset	❑numbness in fingers		❑numbness in toes
❑ringing in ears	❑shortness of breath	❑ pins and needles in arms		❑pins and needles in legs

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES If yes, When?_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____

ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____

_____

ARE YOU PREGNANT ? ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD? _____

PLEASE READ CAREFULLY;

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment and if collected by an attorney, by suit or otherwise, I, or we, agree to pay all fees and collection costs.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

In addition to the above, I understand that I have been given the opportunity to read and review the Kirk & Kirk Health Clinic, P.C. Notice of Privacy Policies.

Patient's Signature:_____ Date:_____

Parent or Guardian's Signature:_____ Date: _____

CONSENT FOR TREATMENT
&
AUTHORIZATION TO PERFORM X-RAYS

I understand that diagnostic x-rays may be necessary so that a complete analysis can be made of my present musculoskeletal problem. Therefore, I authorize **Dr. Mike Dwain Kirk** to perform the radiographic examinations necessary to diagnosis and to administer whatever treatment deemed necessary to treat my present condition (symptoms).

Signed:_____

FEMALE PATIENTS ONLY:
To the best of my knowledge I am **NOT pregnant** and **Dr. Mike Dwain Kirk** has my permission to x-ray me for diagnostic interpretation.

Signed:_____

03/09/12

Authorization to Release Information

KIRK & KIRK HEALTH CLINIC, P.C.
1539 WEST ANDREW JOHNSON HIGHWAY
MORRISTOWN, TN 37814

NAME:_____**DATE OF BIRTH:**_____

I hereby authorize the following individual(s), other than myself, to receive information regarding my healthcare, diagnostic results, appointments, billing and/or collections:

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

* *

I hereby authorize Kirk & Kirk Health Clinic, P.C. to leave messages pertaining to my appointments, billing, and/or collections at the following numbers (on file or given on current message):

____ cell phone #_____

____ home phone #_____

____ work phone #_____

____ other # _____

Patient Signature:_____**Date:**_____