

# Kirk & Kirk Health Clinic, P.C.

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

## Confidential Patient Data

### PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_  
Job Title \_\_\_\_\_ Are you a full time student? \_\_\_\_\_  
Your Employer: \_\_\_\_\_  
Address of Employer \_\_\_\_\_

Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred to this office by:  Yellow Pages  Mail  Friend  Other \_\_\_\_\_  
 Family Member - Name \_\_\_\_\_ Relation \_\_\_\_\_

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

Please Rate Your Symptoms (1-10, with 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  
shocklike numb come & go are constant

**PAIN IS:** local travels 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. Futhermore, 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 D. 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 D. Kirk** has my permission to x-ray me for diagnostic interpretation.

Signed:\_\_\_\_\_

**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: \_\_\_\_\_

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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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 \_\_\_\_\_

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_