Kirk & Kirk Health Clinic, P.C. July 2015

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

CONFIDENTIAL PATIENT DATA

Claim #: _____ **Today's Date:** _____

Last Name:_____First:_____Middle:_____

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

Social Security #:_____ Ethnicity: _____

Race:_____ Age: _____ Primary Language: _____

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

Address: _____

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

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

Please indicate which # you prefer we call… ❑ home ❑ cell ❑ work

Employer Name_____ Are you a student?_____

Job Title:_____

Emergency Contact & Relation:_____Phone:_____

Referred by: ❑Family ❑ Friend: Name_____
❑ Internet ❑Yellow Pages ❑Other_____

Payment: ❑Cash/Check/Credit Card ❑Health Insurance ❑Auto Insurance ❑Worker's Comp

Name of Insurance Co.:_____

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

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

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:
****** Be Specific, example: (Upper, Mid, Low, Left, Right… etc.)**

****** Rate Your Symptoms 1-10**
(1 being least serious)

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

ARE SYMPTOMS WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT

SYMPTOMS DEVELOPED FROM: ❑ WORKER'S COMP CLAIM ❑ AUTO ACCIDENT CLAIM ❑ ILLNESS
❑ OTHER ACCIDENT ❑ UNKNOWN CAUSE ❑ OTHER

DATE OCCURRED? _____

HOW OCURRED? _____

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 (which are available in the waiting area).

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:_____ **Date:**_____

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:_____