

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____ - _____ - _____ Marital Status: _____

Gender at Birth: _____ Preferred Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Can messages be left? Yes No

Alternate Phone: _____ Can messages be left? Yes No

Email: _____ Race: _____ Ethnicity: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Contact who doesn't live with you: _____ Phone: _____

Primary Doctor: _____ Referring Doctor: _____

Primary Insurance Plan: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Secondary Insurance Plan: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Insurance Claim Authorization / Consent for treatment:

I authorize the release of any medical information necessary to process my insurance for services rendered.

Signed: _____ Date: _____

Medicare Recipients:

I request that payment of authorized Medicare benefits be made on my behalf for any services rendered to me by Donna O'Neill, MD and Vivek Kak, MD. I authorize any holder of medical information about me to release to Health Care Financing administration and its agents, any information needed to determine these benefits or the benefits payable for related services until rescinded.

Signed: _____ Date: _____

Privacy Notice:

Your care and all information related to it are very important to us. We will share this information only with those necessary to provide you with the care needed and/or those you have given us written release for. Due to the type of practice this is, many patients are seen in an "open setting." If at any time you do not feel comfortable or appropriate in an area you are in, you have the right to request to be moved to a more confidential location. A full "Notice of Privacy Practices" is displayed in the waiting room, or a copy is available upon request. Please notify Dr's. O'Neill, Kak or the Office Manager if you have any concerns regarding the handling of your medical information.

Signed: _____ Date: _____

DATE: / /2024

SOCIAL HISTORY:

How much beer / wine / alcohol do you drink? # _____ per (Please circle) : Week Month Year

Have you had your flu vaccine this year?	NO	YES	<input type="checkbox"/> Declined
Have you ever had the pneumonia/pneumococcal vaccine?	NO	YES	I Don't Know
Have you been vaccinated for COVID-19?	YES	NO	Date of Last Vaccine: _____ <input type="checkbox"/> Declined
Have you had COVID?	NO	YES	If Yes, # of times: _____ When: _____

Have you ever smoked or chewed tobacco? NO YES

If yes, do you now? NO YES

When did you quit? _____

How many packs per day do you / did you smoke? _____

How many years have you / did you smoke? _____

Have you ever vaped or used smokeless tobacco? NO YES **Do you vape now?** NO YES

Do you use recreational marijuana? NO YES

Are you interested in quitting any of the above? NO YES: _____ N/A

Have you ever had a Hepatitis C test done?	NO	YES - Negative or Positive	Declined
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Over the past 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3

Has anyone close to you tried to harm / hit you?	No	Yes
Do you feel controlled or isolated by your partner?	No	Yes
Do you feel safe at home?	No	Yes

Have you <u>EVER</u> had :										
Sexually Transmitted Disease	No	Yes	Please circle: Syphilis Warts Herpes Chlamydia Ghonorrhea							
Tattoos	No	Yes	How Many?							
Overseas Travel - Any	No	Yes	Where:							
Current Pets / farm exposure	No	Yes	Dog	Cat	Bird	Pig	Chicken	Cow	Sheep	Horse

PLEASE CIRCLE IF YOU EVER HAD or HAVE:

Artificial Joint(s)

(R / L Knee – R / L Hip – R / L Shoulder)

Heart Valve (Aortic / Mitral / Tricuspid)

Loss of hearing / Hearing Aids / Ringing in the ears

Bad vision / Glaucoma / Macular Degeneration

Metal fragments removed from your eyes

Sinus trouble

Mouth problems

Sleep Apnea / CPAP or BIPAP

Asthma

Daily cough

Pneumonia and admitted

Bronchitis

Shortness of breath

Emphysema / COPD / On Oxygen

Tuberculosis

Rheumatic fever

High cholesterol/triglycerides

High blood pressure

Circulation problems/where: _____

Pacemaker

Irregular heart beat / atrial fibrillation

Heart attack

Heart murmur

Congestive heart failure

Swollen ankles/ edema

Stomach ulcers/ GERD / H. Pylori

Trouble Swallowing

History of C. difficile

Crohn's disease / Ulcerative Colitis

Chronic constipation

Irritable bowel disease

Cirrhosis or Hepatitis

Enlarged Prostate

Kidney stones and / or infections

Urinary incontinence / leakage

Kidney failure

On dialysis where? _____

What days? _____

Cancer - what type: _____

Bleeding / Clotting problems

Drenching night sweats

Unintentional weight loss: amount _____

Skin problems - what: _____

Sore joints – where: _____

Autoimmune disease (Rheumatoid, Lupus, other)

other : _____

Numbness - where: _____

Dementia / Alzheimers

Parkinson's

Multiple sclerosis

Stroke or TIA

Depression

Schizophrenia

Bipolar disorder

Obsessive compulsive disorder

Anxiety disorder/panic attacks

Headaches: tension, migraine, sinus, other

Hypothyroidism or Hyperthyroidism

Osteoporosis or Osteopenia

Reviewed and none of these apply

Diabetes: NO YES Type: I or II

On Insulin? YES NO Duration: _____

Does it affect your: Eyes, Kidneys, Circulation,
Skin, neuropathy, history of foot infection

Recent Hemoglobin A1C _____

Control is [circle]: good fair poor

MD SIGN: _____ Date: / / 2024

All Others Negative