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and its agents, any information needed to determine these benefits or the benefits payable for related services until rescinded.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:** _____

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214 North Elm Avenue, Jackson, Michigan, 49202 Phone: 517-788-4781 Fax: 517-788-4799

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Name: _____ **Latex Sensitivity:** □NO □ YES **DATE:** _____

Your Pharmacy: _____

****Allergies:**** _____

_____

LIST ALL MEDICATIONS, VITAMINS, & SUPPLEMENTS YOU TAKE:

□ **I'm not taking any medications at this time**

DRUG NAME	DOSE	HOW TAKEN? / Frequency	D/Cdate

OFFICE USE ONLY

Date/initial								

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NAME: _____ DATE: _____

OCCUPATION: _____ AGE: _____

PRIMARY DOCTOR: _____ REFERRING DOCTOR: _____

I AM HERE TODAY BECAUSE: _____

_____

HOSPITAL ADMISSIONS: please list all

YEAR	ILLNESS/OPERATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

LIST WHICH BLOOD RELATIVES HAVE HAD THE FOLLOWING:

Heart attack/disease: _____

Stroke: _____

Cancer: _____

Tuberculosis: _____

Diabetes: _____

Dementia: _____

Lung disease: _____

Autoimmune disease: _____

High blood pressure: _____

Kidney disease: _____

Liver Disease or Alcoholism: _____

Other: _____

Are you Married NO YES # of times: _____ **Divorced Widowed?**

Do you have children? NO YES how many: _____

Who do you live with: _____

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DATE: / /2026

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**
Have you ever had a Hepatitis C Test?	**No**	**Can't Answer**		
	Yes	**Negative Result**	**Positive result**	

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

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? NA NO YES: _____

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 EVER 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

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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
COVID
Shortness of breath
Emphysema / COPD / On Oxygen
Tuberculosis
Rheumatic fever
High cholesterol/triglycerides
High blood pressure
Circulation problems/where:_____
Pacemaker
Irregular heartbeat / 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 :_____
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

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 _____ Date:
Control is [circle]: good fair poor

□ Reviewed and none of these apply

MD SIGN: _____ Date: / / 2026
□ All Others Negative

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