Patient Information

Name: _____
Date of birth: _____ Age: _____ Last 4 digits of SS#: _____ Married/Single/Divorced/Widowed
Address: Street: _____ City: _____ State: _____ Zip: _____
Telephone numbers:
Home: _____ Cell: _____ Work: _____
Employer: _____ (If the patient is a minor, list the guardian's employer)
Employer's address: _____
Emergency Contact: _____

RESPONSIBLE PARTY (PRIMARY INSURED)
Insurance Company: _____
Name of Insured: _____ Date of birth (of insured): _____
Address of Insured: _____ Social Security #: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
SECONDARY INSURANCE
Insurance Company: _____
Name of Insured: _____ Date of birth (of insured): _____
Social Security #: _____

Communication by texting and email is convenient, efficient, and a part of daily life for many people. It is important that you understand that email and text communications between you and us are not encrypted and therefore not secure. If you communicate with us from your workplace computer, your employer and its agents may have access to these communications. Any email communication between you and us may become part of your medical record and be accessible to the office staff as needed.

- ☐ Yes, I consent to texting communication with Dr. Kunkel and the office staff
- ☐ I understand that I am responsible for providing Dr. Kunkel's office staff of any updates to my email address
- ☐ I understand that I may revise or withdraw my consent at any time by notifying the office of this desired change
- ☐ No, I prefer not to have email communication
- ☐ No, I prefer not to have text communication
- ☐ Please list your email address only if you authorize Dr. Kunkel and the office staff to communicate with you by email: _____

We use an electronic medical record system in the office. To allow more effective coordination of your care with others involved in your care (doctors, hospitals, labs, pharmacies, radiology centers, etc.), the electronic record system may be connected to a secure health information exchange. Please place a check mark in the appropriate box:

- ☐ I agree to allow my records to be communicated via the internet secure health information exchange in order to aid in coordinating my care.
- ☐ I do not want my records to be communicated via the internet secure health information exchange. I understand that this decision means that information that is important to my care may not be communicated as efficiently.

We also utilize TouchMD in the office. TouchMD is an internet-based company that helps us create a more thorough, complete educational experience. By creating a private, password-protected account with TouchMD, you can access diagrams and videos of procedures that are of interest to you. Photographs that we take of you are sent electronically to TouchMD, which then allows you to view the photos in the comfort of your own home or on your mobile device. Please check the appropriate box:

- ☐ I agree to use the TouchMD service, allowing me to view diagrams, videos, and my photographs through a password-protected internet connection created by TouchMD.
- ☐ I do not want to participate in the use of the TouchMD service. I do not wish to see additional videos or diagrams or my photographs through this system.

INSURANCE AUTHORIZATION
I hereby authorize Kelly R. Kunkel, M.D., P.A., and authorized office personnel to furnish information to insurance carriers concerning my health and treatment and I hereby assign Kelly R. Kunkel, M.D., P.A. all payments for services rendered to my dependents or myself. I understand that I am responsible for any charges incurred regardless of insurance coverage.

SIGNATURE: _____ **DATE:** _____

Patient Information

Health Information

What is the reason for your visit today? _____
Have you seen another physician related to this concern? If so, who and when? What was done at that time?
_____

Please list other physicians involved in your care:
Primary care physician: _____ Cardiologist: _____
Dermatologist: _____ Other: _____
Ob-gyn physician: _____

List any allergies you have (medications, food, etc.): _____

Have you ever used a nicotine product routinely (cigarettes, e-cigarettes, nicotine gum or patches, Juul)? ___ Yes ___ No
If yes, please describe: _____
Do you drink alcohol? If so, how much and how often_____

What is your approximate height? _____ feet _____ inches What is your approximate weight? _____ lbs.

Do you take aspirin: daily? ____Yes ____No
just for headaches? ____Yes ____No
If you take aspirin daily, how much do you take? ____ 'baby' aspirin (81mg) ____ 'regular' aspirin (325 mg)

Please list medications, vitamins and herbal supplements that you take:

Name	Dose	How Often

Check any illnesses or conditions YOU have had:

[ ] Diabetes [ ] High blood pressure
[ ] Heart failure [ ] Heart attack
[ ] Asthma [ ] Other lung issue
[ ] Hepatitis/jaundice/liver problems
[ ] Bleeding disorder [ ] Blood clots
[ ] Rheumatoid arthritis [ ] HIV
[ ] Kidney problem [ ] Autoimmune disorder
[ ] Stroke/seizure [ ] cancer (list): _____

Please mark any operations you have had, and list the approximate year:

[ ] Heart bypass _____ [ ] Pacemaker _____ [ ] Coronary artery stent _____
[ ] Hernia repair _____ [ ] Appendectomy _____ [ ] Gallbladder _____
[ ] Cesarean section _____ _____ _____ [ ] Hysterectomy _____ [ ] Tubal ligation _____
[ ] Surgery on ovaries _____ [ ] Thyroid surgery _____ [ ] Prostate surgery
[ ] Weight loss surgery (lap-band, gastric sleeve, gastric bypass) _____
[ ] Skin cancer (describe) _____
[ ] Other surgery _____

Thank you for your assistance in providing this information!