



# 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!***