

Kindra S. Browning, D.O.
Board Certified Internal Medicine

To All of My New Patients,

Please fill out the Health History form and bring it with you to your scheduled appointment. It is extremely important that you bring all of your current insurance information. Please bring all of your medications with you, including Vitamins and Herbs. Please arrive 15 minutes early for your appointment as there will be papers to sign. If you are unable keep this appointment, please call and reschedule. If you are 15 minutes late, your appointment will be rescheduled.

Thank you for your help in assisting us to serve you better.

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HEALTH HISTORY

NAME _____ OCCUPATION _____

Date of Birth _____

PAST ILLNESSES

- Asthma
- Hay Fever
- TB (Tuberculosis)
- Kidney Problems
- Heart Problems
- High Cholesterol
- Rheumatic Fever
- Diabetes
- Stroke
- Cancer – Type _____
- Anemia
- Abnormal Pap Results
- Ulcers
- Mental Illness
- Seizures
- Depression
- Back Problems
- Thyroid Disease
- Gall Stones
- Hepatitis- A B C
- Liver Problems
- Bleeding Problems
- Skin Problems
- Alcohol Problems
- Drug Problems
- Hearing Loss
- Sexually Transmitted Disease
- HIV or AIDS
- Headaches
- Vision Problems
- High Blood Pressure
- Irregular Periods
- Other _____
- _____
- _____

IMMUNIZATIONS

- | | Year |
|--------------------------------------|-------|
| <input type="checkbox"/> Rubella | _____ |
| <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> Tetanus | _____ |
| <input type="checkbox"/> Hepatitis B | _____ |
| <input type="checkbox"/> Pneumovax | _____ |
| <input type="checkbox"/> Flu Vaccine | _____ |
| <input type="checkbox"/> Other | _____ |
| _____ | _____ |
| _____ | _____ |

ALLERGIES

Please check any allergies that you have had and write down the reactions.

- Penicillin _____
- Sulfa _____
- Aspirin _____
- Codeine _____
- Bee Stings _____
- Foods _____
- _____
- Other _____
- _____

ALCOHOL USE: Yes _____ No _____ Quit _____
Amount _____ How Often _____

TOBACCO USE: Yes _____ No _____ Quit _____
Type _____ Amount Per Day _____

SURGERIES

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Uterus | <input type="checkbox"/> Fallopian Tubes |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Other _____ | |

HOSPITALIZATIONS

Please list dates and reason for each hospitalization

DATE	REASON
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please list any medications you take, both prescription and over-the-counter. Give dosage and how often taken.

DRUG	DOSE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Kindra S. Browning, D.O.

Date: _____

NEW PATIENT INFORMATION

Patient Name (Last, First, Initial): _____

Sex _____ Marital Status _____ Age _____ Birthdate _____ Social Security # _____

Patient Address _____

City _____ State _____ Zip _____ Telephone _____

Patient's Employer _____ Business Telephone _____

Employer's Address _____

City _____ State _____ Zip _____

INSURANCE INFORMATION

Insured's Name (Last, First, Initial): _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Social Security # _____ Birthdate _____

Primary Insurance _____ Policy # _____ Group # _____

Does your Insurance company require pre-authorization on procedures over \$200? _____

Relationship to Patient _____ Birthdate of Spouse _____

Secondary Insurance _____ Policy # _____ Group # _____

Relationship to Patient _____

Medical Card (Case Number) _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

In case of an emergency, the nearest relative's name (other than spouse) _____

Relationship _____ Telephone _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this form and have completed all answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my health status of the above information.

I authorize the release of any medical information necessary to process this claim. I further authorize payment of medical benefits to Kindra S. Browning, D.O. for all services rendered.

Signature _____ Date _____

FOR MEDICARE PATIENTS ONLY
Statement to Permit Payment of Medicare Benefits to Provider, Physician and Patient.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or to _____
_____ on any bills for services rendered me by Kindra S.
Browning, D.O.

Signature of Patient

Date Signed

Health Insurance Claim Number