CHARLES W. KENT, MD, INC

Patient Sign-In Sheet

Patient Name: _____ DOB: ____/____/____

Address: _____

Primary Phone No: (_____) _____ - _____ Secondary Phone No: (_____) _____ - _____

Insurance: _____ *PLEASE PROVIDE YOUR INSURANCE CARD AND VALID ID*

Reason for visit: □ physical □ medication refill □ sickness/injury
□ diabetes □ blood pressure □ other _____

Any changes in your family medical history (parents, siblings, children)? □ No □Yes
If yes, please explain: _____

Any current tobacco/nicotine use? □ No □ Yes
If yes, what type of tobacco/nicotine?
□ cigarettes ____ pack/day □ cigars □ vape/e-cigarette □ chew/dip/snuff

Any current alcohol use? □ No □ Yes
If yes, how many drinks per week?
□ 10 or more drinks □ 6-9 drinks □ 2-5 drinks □ 1 drink or less per week.

Any current marijuana use? □ No □ Yes

On average, how many days per week do you exercise for at least 20 minutes continuously?
□ I do not exercise this much □ 1-2 □ 3-4 □ 5 or more

Please rate your pain (circle your current pain level):

0	1	2	3	4	5	6	7	8	9	10
no pain		mild		moderate		distressing		severe		unbearable - you request an ambulance

SYMPTOMS (please check *CURRENT* symptoms below):

Constitutional symptoms:
□ Fever
□ Extreme fatigue

Eyes:
□ Double vision
□ Blurred vision

Ears/Nose/Throat:
□ Ear pain
□ Decreased hearing
□ Runny nose
□ Sore throat

Cardiovascular:
□ Chest pain
□ Heart palpitations

Respiratory:
□ Cough
□ Wheezing
□ Shortness of breath

Gastrointestinal:
□ Loss of appetite
□ Nausea
□ Vomiting
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Blood in stools

Genitourinary:
□ Frequent daytime urination
□ Frequent nighttime urination
□ Painful urination
□ Urine leakage
□ Blood in urine

Skin:
□ Rash
□ Changing mole(s)
□ Change in hair or nails

Musculoskeletal:
□ Pain located _____
□ Muscle weakness

Neurological:
□ Headache
□ Lightheadedness or dizziness
□ Numbness or tingling
□ Recent fall(s)
□ Memory loss

Psychiatric:
□ Depression
□ Anxiety
□ Suicidal thoughts

Endocrine:
□ Excessive thirst

Hematologic:
□ Unusual bruising or bleeding
□ Enlarged lymph nodes

I understand that payment is due at time of service and agree to pay all charges in full. I authorize and direct my insurance carrier(s) to issue payment directly to Charles W Kent, MD, Inc. I have requested medical services from Charles W Kent, MD, Inc and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment. I understand that I am responsible for any amount not covered by my insurance. I authorize Charles W Kent, MD, Inc to: 1) release any information necessary to insurance carriers regarding my treatment, 2) process insurance claims generated in course of examination or treatment, and 3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. Digital records are prohibited on the premises in order to protect the privacy of other patients and staff.

Patient/Guardian Signature_____ **Date**_____