Western Kentucky Medical Group

Name:

Last:_____First:_____Middle:_____
Maiden:_____Marital Status:_____Date of Birth:_____
Address:_____
City:_____ State:_____Zip:_____Social:_____
Pharmacy Name:_____

Contact Info:

Home Phone:_____Cell:_____ Work:_____
Other:_____ Email:_____

Emergency Contact:

Name:_____ Phone Number: _____

Insurance: (Provide card to front desk)

Primary INS:_____ID:_____
Secondary INS:_____ID:_____

Current Medications: Please list any over the counter medications as well

Medication	Dosage	How Often

Medication Allergies: Please list all prescription or over the counter medication allergies. Also state the type of reaction.(For example, rash or hives) If none, STATE NONE.

_____
_____
_____

Personal Current Medical History: Please check all that apply to you.

- ☐ Heart Attack
- ☐ Migraines
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Asthma
- ☐ Stroke
- ☐ Allergies
- ☐ Anxiety
- ☐ COPD
- ☐ Cancer, What kind_____
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Liver Disorder
- ☐ Thyroid Disease
- ☐ Pancreas Disorder
- ☐ Depression
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Hearing Loss

Family Medical History: (blood relatives only)

If your Mother, Father or Siblings have the following:

	Mother	Father	Sibling
Heart Disease	☐	☐	☐
Asthma	☐	☐	☐
COPD	☐	☐	☐
Kidney Disease	☐	☐	☐
Glaucoma	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Stroke	☐	☐	☐
Anxiety/Depression	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
Osteoporosis	☐	☐	☐
Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐

Previous Surgeries:

Have you ever had surgery? _Yes _No If yes, please list date(s) and what kind.

_____

_____

_____

Social History:

Do you drink alcohol? _ Yes _ No If yes, how much per day, and for how long?

_____

Do you use recreational drugs? _ Yes _No If yes, type/amount and how long?

_____

Do you smoke cigarettes? _ Yes _No If yes, how many packs/day and how long?

_____

Do you use smokeless tobacco? _Yes _No If yes, how much and how long?

_____

Medical Information Release:

__ DO NOT release any information to anyone except me

__ You have my permission to disclose information to the following person(s)

_____

_____

_____

_____

Patient/Guardian Signature:_____

Date: _____

Patient Name: _____Date of Birth:_____

Financial Responsibility:

I (the patient) hereby agree to pay for all services rendered at Western Kentucky Medical Group. I am aware that if I do not have insurance. I will be responsible for any services rendered. I will pay in full any balance due to WKMG.

Consent for Treatment:

I (the patient) hereby authorize the doctor/nurse practitioner at Western Kentucky Medical Group to administer local anesthetics and/or medications necessary to perform simple surgical procedures and diagnostic procedures, as may be deemed advisable in diagnosing and treatment of the patient. I (the patient) acknowledge that the use of AI scribe charting services will be carried out with appropriate safeguards in place to protect my privacy and confidentiality, in accordance with HIPAA and other relevant regulations.

Consent for Disclosure of Medical Information:

I (the patient), hereby grant authorization to release from Western Kentucky Medical Group such information as may be necessary for the completion of my medical claims. Also, by signing. I realize that I am authorizing WKMG to make referrals and distribute any necessary information regarding my condition. In addition, I am entitled to one free copy of my own medical records upon request.

Controlled Substance Agreement/Kasper Reports:

I (the patient) understand that while receiving controlled substances from Western Kentucky Medical Group. I am not allowed to receive controlled substance prescriptions from any other doctors. I also understand and consent that I will be asked to give random urine drug screens at any time while being prescribed these medications. I also authorize the doctor/nurse practitioner at WKMG to run KASPER reports when prescribing controlled substances.

Advance Directive: (check below)

__ I (the patient), have my living will
__ A copy of my living will is on file at _____
__ I do not have an Advance Directive, but have received information about Advance Directives.

Signature of Patient:

I (the patient) have read the above statements and given my consent.
X_____ Date:_____

Western Kentucky Medical Group
116 Main St. Cadiz KY 42211
Phone:(270) 350-4504 Fax:(270) 350-4590

Authorization for Use of Protected Health Information

Patient Name: _____

Date of Birth:_____ Social:_____

I authorize Western Kentucky Medical Group to:
___Release medical records to: ____ Obtain medical records from:

Practice Name:_____

Address:_____

Phone:_____ Fax:_____

Purpose or Request:

__Continue Care __Insurance Claim __Attorney __Personal Use __Other

Information Requested:

__Entire Medical Record __Other

__ I specifically authorize release of info pertaining to: HIV/AIDS, Alcohol/Drug Abuse treatment, Mental Health, and/or Genetic Testing.

It is understood that my records may not be released to in.e at the same time requested. You may revoke or terminate the authorization by contacting the medical records department. I understand, however, that revocation will not apply to information that has already been released to this authorization. I understand that if the person(s) or entity that receives this information is not a healthcare provider or health plan Covered by Health Insurance Portability and Accountability Act of 1966 (HIPPA), the information described above may be re-disclosed and is no longer protected by those regulations. Therefore,I release Western Kentucky Medical Group, -Its emp\oyees and Providers, from all liability arising from this disclosure of health. I understand that I am entitled to ONE FREE COPY of my medical records during my lifetime. Any additional copies sent for any reason are subject to a copy fee of $15.00.

_____

Patient Signature Relationship to patient Date

_____

Witness Signature Date