Patient Information

Name______________________________ Date of Birth__________________ SS# ________________

Birth Sex: M or F Identified Gender________________ Race/Ethnicity________________________

Marital Status______________________ Occupation____

Address___________________________________ City___________________ State_____ Zip_______

Cell Phone_______________ Home Phone________________ Email_____________________________

How did you hear about us? ____

Insurance Information

Primary Insurance ____

Address ____

Policy No._____________________________________ Group No. ______________________________

Secondary Insurance____

Address____

Policy No.____________________________________ Group No. _______________________________

Communication Authorization

I, ___________________________________ authorize the staff of Pamela S. Kennedy, M.D. to notify me of my diagnostic/lab results over the telephone by either of the following:

____ Speak **directly** with myself or authorized person ***OR*** ____ Okay to leave a voicemail message

List any other persons authorized to accept results or make changes to appointments:

Name________________________ Relationship____________________ Phone____________________

Name________________________ Relationship____________________ Phone____________________

Name________________________ Relationship____________________ Phone____________________

Patient History

Name__________________________ Date of Birth_______________ Height_______ Weight_______

Reason for today's visit ____

Primary Care Physician (PCP) ____

Pharmacy____________________________ Address ____

Medications:
Allergies:

Check if you have any of the following:

Pacemaker		Blood Thinners/Aspirin		Irregular Heartbeat	
Heal: Thick Scar		Joint Pain		High Blood Pressure	
Seizures		Hay Fever		Hypercholesterolemia	
Pregnant/Planning/Breastfeeding		Thyroid Disorder: Hyper/Hypo		Artificial Valves/Joints	
Diabetes		Hepatitis		Immune Deficiency/HIV	
Depression		Liver Disease		GI/GERD (Reflux)	

Other Conditions ____

Surgeries ____

Do **you** have a history of **skin cancer**? Yes or No If yes, which type?______________________________

Do you have a **family history** of Melanoma? Yes or No If yes, relation?___________________________

Do you smoke cigarettes? Yes or No Do you have a healthcare proxy? Yes or No

Do you consume alcohol? Yes or No Do you have a living will? Yes or No

For Females only:

Are you having menstrual cycles? Yes or No Date of last menstrual cycle ________________________

Have you had a hysterectomy? Yes or No

Are you sexually active? Yes or No Form of Contraception ____________________________________

By signing below:

- I certify all information is true and correct to the best of my knowledge.
- I agree to adhere to all policies and procedure while in the care of the office of Pamela Kennedy, MD

Signature____ Date __________________________