



# KESTENBERG SURGICAL GROUP

## Patient History Questionnaire - New Patient

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

S.S.#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Next of Kin/Emergency Contact (name and phone #): \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_ patient? \_\_\_\_\_ doctors office? \_\_\_\_\_ other?

Referral Doctor: (if checked above) \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Other: (if checked above) \_\_\_\_\_

Employed? \_\_\_\_\_ if yes,  full time  part time

Employer: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### INSURANCE INFORMATION

#### PRIMARY INSURANCE:

Type of Insurance: \_\_\_\_\_

Policyholder: \_\_\_\_\_

Policyholder Birthdate: \_\_\_\_\_

Policyholder S.S.#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policyholder Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### SECONDARY INSURANCE:

Type of Insurance: \_\_\_\_\_

Policyholder: \_\_\_\_\_

Policyholder Birthdate: \_\_\_\_\_

Policyholder S.S.#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policyholder Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_\_\_

Height: \_\_\_\_\_ Weight \_\_\_\_\_

**CHIEF COMPLAINT:** (What brought you to the doctor today?)

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**Is this condition work related?:**     YES     NO

**Past Medical History:** (Do you have a history of any of the following?)

<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Other: _____		

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**Past Surgical History:** (Have you had any surgery before?)     Yes     No

If yes, please list procedure and date:

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**Allergies:** (Do you have any allergies to medications?)     Yes     No

If yes, please list:

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Are you allergic to latex products?     Yes     No

**Medications:** (List all prescription medications you take; include dosage and frequency. Insulin, inhalers and patches should be included here)

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(List all non-prescription medications you take routinely)

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Social History:**

Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No How much? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No How much? \_\_\_\_\_  
What type of job do you have? \_\_\_\_\_

**Family History:** (Do any illnesses run in your family?)

**Review of Systems:** (Please check if you have any of the following)

**CONSTITUTIONAL**

\_\_\_\_\_ Fever  
\_\_\_\_\_ Weight loss  
\_\_\_\_\_ Lethargy

**EYES**

\_\_\_\_\_ Blurred vision  
\_\_\_\_\_ Cataracts  
\_\_\_\_\_ Glasses/Contacts

**CARDIOVASCULAR**

\_\_\_\_\_ Shortness of breath  
\_\_\_\_\_ Chest pain (angina)  
\_\_\_\_\_ Heart palpitations  
\_\_\_\_\_ Cold extremities

**EARS, NOSE, MOUTH & THROAT**

\_\_\_\_\_ Tinnitus  
\_\_\_\_\_ Nose bleeds  
\_\_\_\_\_ Nasal congestion  
\_\_\_\_\_ Sore throat  
\_\_\_\_\_ Difficulty swallowing

**RESPIRATORY**

\_\_\_\_\_ Chronic cough  
\_\_\_\_\_ Wheezing  
\_\_\_\_\_ Cough blood  
\_\_\_\_\_ Productive cough  
\_\_\_\_\_ Asthma

**GASTROINTESTINAL**

\_\_\_\_\_ Pain  
\_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Constipation  
\_\_\_\_\_ Blood in stool  
\_\_\_\_\_ Mucus in stool  
\_\_\_\_\_ Nausea  
\_\_\_\_\_ Vomiting  
\_\_\_\_\_ Vomit blood  
\_\_\_\_\_ Heartburn  
\_\_\_\_\_ Change in stool  
\_\_\_\_\_ Food intolerance  
\_\_\_\_\_ Loss of appetite

**GENITOURINARY**

\_\_\_\_\_ Frequency  
\_\_\_\_\_ Blood in urine  
\_\_\_\_\_ Abnormal urine color  
\_\_\_\_\_ Painful urination  
\_\_\_\_\_ Awaken to urinate  
\_\_\_\_\_ Unable to fully empty bladder  
\_\_\_\_\_ Incontinence

**MUSCULOSKELETAL**

\_\_\_\_\_ Pain  
\_\_\_\_\_ Limited range of motion  
\_\_\_\_\_ Limited strength  
\_\_\_\_\_ Arthritis

**NEUROLOGICAL**

\_\_\_\_\_ Headache  
\_\_\_\_\_ Fainting  
\_\_\_\_\_ Dizziness  
\_\_\_\_\_ Memory loss  
\_\_\_\_\_ Numbness

**INTEGUMENTARY**

\_\_\_\_\_ Rash  
\_\_\_\_\_ Itching  
\_\_\_\_\_ Dry Skin

**HEMATOLOGIC/LYMPHATIC**

\_\_\_\_\_ Easy bruising  
\_\_\_\_\_ Anemia  
\_\_\_\_\_ Blood abnormalities  
\_\_\_\_\_ Blood thinners  
\_\_\_\_\_ Lymph node enlargement

**ENDOCRINE**

\_\_\_\_\_ Night sweats

Reviewed by Physician \_\_\_\_\_

**Breast Patients Only:** (Please complete the following to help assess your risk for breast cancer.)

- 1. How many times have you been pregnant? \_\_\_\_\_
- 2. How many children did you give birth to? \_\_\_\_\_
- 3. How old were you when you gave birth to your first baby? \_\_\_\_\_
- 4. Did you breast feed the babies? \_\_\_\_\_
- 5. How old were you when you had your first menstrual period? \_\_\_\_\_
- 6. If you are post-menopausal, what was the age of onset of menopause? \_\_\_\_\_
- 7. Are you on any hormone replacement therapy? \_\_\_\_\_
- 8. Have you ever had an abnormal mammogram or breast mass? \_\_\_\_\_
- 9. Have you ever had a breast biopsy or cyst aspiration? \_\_\_\_\_
- 10. Have you ever had breast cancer? \_\_\_\_\_
- 11. Do you have any relative (maternal) with  
breast cancer \_\_\_\_\_  
ovarian cancer \_\_\_\_\_  
colon cancer \_\_\_\_\_



Name: \_\_\_\_\_ Date: \_\_\_\_\_

## ACCEPTANCE OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

**FINANCIAL RESPONSIBILITY:** Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We therefore urge you, the patient, to please check with your insurance company prior to any office visit/procedure. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember your insurance policy is between you and your company, not the insurance company and your doctor.

**INSURANCE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to William L. Kestenberg, M.D., P.C. for any services that Dr. Kestenberg has provided to me. I authorize any holder of medical information to release it to the Health Care Financing Administration/Other Insurance Company and it's agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance Company assigned cases, the physician agrees to accept the charge determined as full charge, and the patient is responsible only for the deductible, coinsurance, co-pays and non-covered services. Coinsurance, deductibles and co-pays are based upon the charge determination of Medicare/Other Insurance Company,. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize any holder of information concerning my treatment to release that information to the Social Security Administration and it's intermediaries, insurance carriers or other governmental offices if needed for this or related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information relating to treatment for serious communicable diseases, (as defined by the Michigan Public Health Code), to my Health Plan Administrator, it's agents and representatives, insurance carrier or it's authorized agent, for the purpose of conduction, concurrent or retrospective, of medical review of treatment and services provided by Dr. William Kestenberg.

A photocopy of this assignment shall be considered as effective and valid as the original.

Signature:

\_\_\_\_\_

(Patient)

Signature:

\_\_\_\_\_

(Guardian)

(Relationship)

\_\_\_\_\_

(Witness)