

Ken Denman ARNP

Welcome! This new patient packet contains:

- Patient Welcome Letter
- Patient Medical History
- Consent for Phone Contact Form

Please read each form, fill out and sign the appropriate forms and bring the entire packet to your first visit.

PATIENT WELCOME LETTER

Welcome to the office of **Ken Denman ARNP.**

I pledge to provide:

- personalized, compassionate care
- longer office visits
- the highest quality psychiatric care
- short wait times
- flexible, accessible hours of care
- a peaceful, welcoming office environment
- a commitment to preventive care and health maintenance
- And Most importantly.....A Provider who Listens!

These principles are the essence of my practice. Our mission statement (printed below) is not just rhetoric but the philosophy by which I will conduct myself **every** day with **every** patient. I do this because..... **I Care!**

Ken Denman ARNP

This practice is geared toward and limited to patients who are highly motivated to seek optimal health and who are willing to actively participate in their own health care. We will tailor the treatment plan to your individual needs and provide you with information and guidance which will assist you in seeking health and enable you to become more self-reliant. If you are the kind of patient who expects everything to be done for you without your active participation in this process, this practice may not be right for you.

Patient responsibilities:

- Please arrive at our office on time for your appointments
- Please provide pertinent past medical records or assist us in obtaining them
- Payments are expected as services are rendered
- We accept cash, personal checks and major credit and debit cards. We will assist you however possible with insurance companies but it is ultimately the patient's responsibility to settle outstanding balances and to contact insurance companies regarding questions of coverage, benefits, etc.
- Because we limit the number of daily appointments and spend long visits with each patient, failure to appear for your scheduled appointment is impolite and unfair to us. Please give us the courtesy of at least 24 hours notice when canceling scheduled appointments. We reserve the right to assess patients a \$50 charge for same day cancellations or "no-shows"

Please bring the attached forms with you to your first visit. If you have questions, please feel free to contact us.

I understand the above policies and would like to become a patient of KEN DENMAN ARNP and to be an active partner in my own health care.

Name of Patient (print) _____

Signature _____ Date _____

Notice of Privacy Practices and Patient Rights

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can obtain access to your health information. This notification is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes.

Name of Patient (print) _____ Signature _____
Date _____

New Patient Demographic Form

Patient Name: _____

(Policy Holder's Name/relationship): _____

Home Address: _____

City/State/Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____

(please circle the number at which we are most likely to reach you)

Email address: _____

Social Security #: _____ Gender: Male / Female Date of Birth: _____

Age: _____

Marital Status: Single Married Partnered Widowed Other:

Spouse/partner's name: _____

Spouse/partner's address & phone #: _____

Emergency contact's name & phone # (if different): _____

Patient's occupation: _____

Employer: _____

Employer's address & phone #: _____

I was referred to this office by: _____

Medical Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy Holder's Birthdate: _____ Policy Holder's Birthdate: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Subscriber ID #: _____ Subscriber ID #: _____

Group Number: _____ Group Number: _____

Patient's signature: _____ Date: _____

New Patient Medical History Form

Name: _____ Today's Date: _____

Date of Birth: _____

Allergies: _____

Problem(s) you are seeking help with:

Occupation:

Major Medical Problems/Conditions/Diseases:

Health Habits:

Check which substances you use and quantity:

Tobacco

Alcohol

Drugs

Caffeine

Past Surgeries/Operations (years):

Stress Levels:
Please rate your stress levels for each category (0-10)

Job:

Home life/relationship:

Children:

Other (specify):

I wear my seatbelt: always/sometimes/never

Sleep/Night (average): _____

Current Medicines/Dosage/Frequency:
(type/frequency/duration):

Exercise routine

Number of children, ages, genders:

Vitamins/Herbal Supplements/OTC Medicines:

Patient Signature: _____ Date: _____

New Patient Medical History Form (page 2)

Please circle each symptom/condition that applies to you:

GENERAL

Anxiety
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Night sweats
Numbness
Sleep Disturbance

CARDIOVASCULAR

Chest Pain
High Blood Pressure
Irregular Heart Beat
Low Blood Pressure
Poor Circulation
Rapid Heart Beat
Swelling of Ankles
Varicose Veins

EYE, EAR, NOSE, THROAT

Bleeding gums
Blurred vision
Difficulty swallowing
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems

GASTROINTESTINAL

Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

GENITO-URINARY

Blood in urine
Frequent urination
Lack of bladder control
Painful urination
Penile discharge
Vaginal discharge

MUSCLE/JOINT/BONE

Pain/Weakness/Numbness in:

Arms
Back
Feet
Hands
Hips
Knees
Legs
Neck
Shoulders

Osteoporosis

Scoliosis

Fractures (which bones):

Date of last tetanus shot? _____

Date of last bone density test? _____

SKIN

Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sores that do not heal

WOMEN ONLY:

Last menstrual period: _____

Last pap smear: _____

Last mammogram: _____

Is it possible that you are pregnant?

Patient Signature: _____

Date: _____

Fill out this section if you suffer from headaches:

Do you suffer from chronic headaches? _____ How often? _____

Do you suffer from chronic migraines? _____ How often? _____

Age of onset _____

Have you been evaluated by a neurologist? _____ Had a CT scan / MRI scan of your brain? When?

Longest interval WITHOUT a headache/migraine over the past year: _____

Known triggers: _____

Please circle each condition that you currently have or have had over the past year:

- | | | |
|---------------------|----------------------------|--------------------|
| AIDS | Glaucoma | Pacemaker |
| Alcoholism | Goiter | Pneumonia |
| Anemia | Gonorrhea | Polio |
| Anorexia | Gout | Prostate Problem |
| Appendicitis | Heart Disease/Heart attack | Psychiatric Care |
| Arthritis | Hepatitis | Rheumatic Fever |
| Asthma | Hernia | Scarlet Fever |
| Bleeding Disorders | Herpes | Seizures |
| Breast Lump | High Cholesterol | Stroke |
| Bronchitis | HIV Positive | Suicide Attempt |
| Bulimia | Kidney Disease | Thyroid Problems |
| Cancer (specify) | Liver Disease | Tonsillitis |
| Cataracts | Measles | Tooth Decay |
| Chemical Dependency | Migraine Headaches | Tuberculosis |
| Chicken Pox | Miscarriage | Typhoid Fever |
| Diabetes | Mononucleosis | Ulcers |
| Emphysema | Multiple Sclerosis | Vaginal Infections |
| Epilepsy | Mumps | Valley Fever |

Family Medical History:

	Age	State of Health	Age of Death	Cause of Death
Father:				
Mother:				
Brothers:				
Sisters:				

<p>Has any blood Relative of yours had: Cancer (type): Diabetes Heart Disease: Hypertension: Mental illness of any kind:</p>

Patient Signature: _____

Date: _____

Consent for Phone Contact Form

If we attempt to contact you and do not reach you in person, please indicate which method(s) of leaving messages are acceptable to you:

- It is OK to leave a voicemail message for me on my
- Home Phone _____
- Cell Phone _____
- Work Phone _____
- Other (specify) _____

-
- It is OK to discuss medical information regarding me with:
 - My husband/wife/partner _____ (print name)
 - My power of attorney _____ (print name, relationship)
 - Other _____ (print name, relationship)

 - Never leave any medical information on any message for me, simply ask me to call back.

 - It is OK to email me with medical information @