El Dorado Internal Medicine, LLC

Dr. H. Richard Kuhns
Dr. Amy Seeber
Dr. Kyle Tipton
Dr. Allison Sollo

New Patient Registration

Patient Information

Last Name:	First Name:	MI:	Marital Status:
Sex at Birth:	Birth Date:	Social Security:	
Address:	City:	State:	
Zip Code:	Home Phone:	Cell Phone:	
Email Address:			

Employer Information

Employer:		Phone:	
Address:	City:	Zip Code:	State:

Spouse or Legal Guardian Information

Last Name:	First Name:		
Relationship to Pt:	Phone Number:		
Employer:		Phone:	
Address:	City:	Zip Code:	State:

Emergency Contact Information

Last Name:	First Name:
Relationship to Pt:	Phone Number:

Primary Insurance

Insurance Company:	Policy Number:
Group Number:	Employer:
Policy Holder First Name:	Policy Holder Last Name:
Policy Holder Social:	Policy Holder DOB:

Secondary Insurance

Insurance Company:	Policy Number:
Group Number:	Employer:
Policy Holder First Name:	Policy Holder Last Name:
Policy Holder Social:	Policy Holder DOB:

Current Medications

If you have a list, please give to your nurse in the exam room.	
Name	Dosage

Chronic Medical Conditions

Hospitalizations

Date	Cause

Allergies

Please list all known allergies.	
Allergen	Reaction

Surgeries

Procedure	Year	Procedure	Year

Family History

Relative	Living		Deceased	
	Age	Health	Age	Cause
Mother				
Father				
Sister				
Sister				
Brother				
Brother				

Drug/Alcohol Use

Tobacco:	Never ☐ Former ☐ Current ☐	How Much:	How Often:
Alcohol:	Never ☐ Former ☐ Current ☐	How Much:	How Often:
Drug Use:	Never ☐ Former ☐ Current ☐	How Much:	How Often:

Immunizations and Screenings

Immunization	Year	Immunization	Year
Tetanus		Pneumonia	
Date of Last Colonoscopy			

Females Only

Are you pregnant? ☐ Yes ☐ No	Last Pap Smear:	Last Mammogram:

Consent for Treatment

1. I authorize any and all health care treatment and diagnostic procedures provided by Dr. H. Richard Kuhns, Dr. Kyle Tipton, Dr. Amy Seeber and/or Dr. Allison Sollo.
2. I agree to be contacted via email with information related to my visit, like: lab results, visit notes and/or appointment reminders.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Internal Medicine, LLC.
4. I authorize payment of medical benefits to Internal Medicine, LLC or their designee for services rendered.
5. I understand that it is my responsibility to provide my current insurance card/cards at time of service. If they are not provided I am responsible for all expenses acquired.

Hippa Policy

Initial: _____ I have been offered a copy of the Privacy Practice and Financial Policy Notice.

_____ _____

Patient or Legal Guardian's Signature | Date

_____ _____

Printed Name | Relationship