

KNEWTSON HEALTH GROUP

Please print all information. If an item does not apply to you, put N/A (not applicable).

Date: _____
Patient's Last Name: _____ First: _____ M.I. _____
Birthdate: ____/____/____ Age: _____ Sex: (circle one) M F S.S. #: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____ Cell: () _____
Marital Status: (circle one) S M W D SEP

Emergency Contact: (out of household) _____ Phone: () _____

***** IF CHILD IS A MINOR, PLEASE FILL OUT PARENTAL/GUARDIAN INFORMATION LISTED BELOW *****

Father: _____ Home Phone: () _____ Work Phone: () _____
Mother: _____ Home Phone: () _____ Work Phone: () _____

Patient's Employer/Occupation: _____
Employer Address: _____

INSURANCE INFORMATION

***** PLEASE SEE NEXT SECTION IF WORK OR INJURY RELATED *****

Primary Insurance: _____
ID #: _____ Group #: _____
Assigned Clinic: _____

***** A WAIVER MUST BE SIGNED IF NOT ASSIGNED TO KNEWTSON HEALTH GROUP**

Policy Holder: Name: _____ Birthdate: ____/____/____
Address: _____ S.S. #: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: () _____

Secondary Insurance: _____
ID #: _____ Group #: _____
Assigned Clinic: _____

Policy Holder: Name: _____ Birthdate: ____/____/____
Address: _____ S.S. #: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: () _____

LIABILITY INSURANCE

Employer: _____ Contact Person: _____
Address: _____ Phone: () _____
Work Comp. or MVA Carrier: _____
City: _____ State: _____ Zip: _____
Phone: () _____ Adjuster's Name: _____
Date of Injury: ____/____/____ Claim # or S.S. #: _____

If Work Comp., did you file a first report of injury with employer? (circle one) Y N

PLEASE READ AND SIGN THE BACK OF THIS SHEET AND GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST. WE BILL AS A COURTESY TO OUR PATIENTS. IF UNSIGNED OR FORM NOT FILLED OUT COMPLETELY, THE PATIENT BECOMES LIABLE FOR ALL CHARGES. THANK YOU.

CO-PAYMENTS: Co-payments are due at the time of service. A \$5.00 service fee will be assessed to your account for co-payments not paid at the time of service.

FINANCIAL ARRANGEMENTS: We would appreciate your payment at the time of service. However, we understand that there may be circumstances in which you will need to make payment arrangements with our business office.

Please present current insurance information at the time of service. Please remember that you are ultimately responsible for any balance that your insurance plan does not cover. We cannot guarantee the amounts of coverage offered by your insurance carrier as each policy is different.

CREDIT POLICY AND PATIENT RESPONSIBILITY: It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. It is your responsibility to know your insurance coverage. If your insurance coverage terminates at the time of appointments, you will be held liable for any costs incurred. In the event your account becomes past due and is referred to an outside agency, you will be responsible for the collection costs along with any reasonable attorney fees.

A FINANCE CHARGE of 1.5% per month, 18% per year, may be imposed on any balance over 90 days old. We would be more than happy to be of assistance to you and your family in any way we can. Should you encounter any difficulties, please notify us as soon as possible to avoid any misunderstanding regarding your account.

To the best of my knowledge I have completed the patient portion of this form, and I have read and understand my financial obligation and patient responsibility.

Date: ____/____/____ Signature of Insured: _____
Responsible Party (if Minor): _____

PAYMENT AUTHORIZATION

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO KNEWTSON HEALTH GROUP

Date: ____/____/____ Signature of Insured: _____
Responsible Party (if Minor): _____

RELEASE OF MEDICAL RECORDS

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AS NECESSARY TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN OR ANOTHER PARTY OF MY DESIGNATION FROM KNEWTSON HEALTH GROUP.

Date: ____/____/____ Signature of Insured: _____
Responsible Party (if Minor): _____

ACKNOWLEDGEMENT:

I acknowledge that I have received Knewton Health Group's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to that information.

Patient or Personal Rep Signature

Relationship to Patient

Date

KNEWTSON HEALTH GROUP QUESTIONNAIRE

Last Name _____ First Name _____ M.I. _____ Date of Birth _____

1. How would you prefer to be addressed? (ie. "Mr. Jones", "Al", etc.): _____
2. List immediate family members and their birthdates: _____

3. Describe your current living situation (ie. "I live with my spouse in our own home"): _____

4. List any medication allergies and your reaction: _____

5. List your current medications and dosages (include vitamins and supplements): _____

6. List current medical conditions and the year of diagnosis (ie. "diabetes since 1993"), including any issues to pain and/or pain management: _____

7. List any surgeries and the year (include vasectomy, wisdom teeth removal, etc.): _____

8. List any other hospitalizations and the year: _____

9. List family members - parents, siblings, children - with significant medical conditions (diabetes, heart attacks, cancer, etc.): _____

Women (questions #10 - #15)

10. Total number of pregnancies: _____
 - Number of Vaginal Deliveries: _____ Dates: _____
 - Number of C-sections: _____ Dates: _____
 - Number of Miscarriages: _____ Dates: _____
 - Number of Abortions: _____ Dates: _____
11. How often do you perform self breast exams? _____ Would you like information? Yes No
12. When was your last mammogram? _____ Have you ever had an abnormal mammogram? Yes No
13. When was your last pap smear? _____ Have you ever had an abnormal pap smear? Yes No
14. When was your last menstrual period? _____ Describe your periods: Regular? Yes No
Frequency _____ Duration _____ Heavy Moderate Light
15. If applicable, what birth control method do you use? _____ Would you like information? Yes No

Continued →

Men (questions #16 - #17)

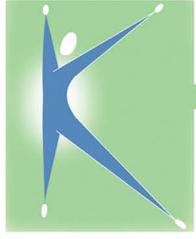
16. How often do you perform self testicle exams? _____ Would you like information? Yes No
17. Have you ever had a PSA test for prostate cancer screening? Yes No

Men and Women (questions #18 - #36)

18. When was your last Tetanus shot? _____ Flu shot? _____ Pneumonia vaccine? _____
19. How often do you wear your seat belt? Always Sometimes Never
20. Describe your caffeine consumption: _____
21. Describe any use of tobacco products now and/or in the past: _____

22. Describe your typical weekly alcohol consumption: _____
23. Describe your use of any other chemicals: _____
24. Without wanting to, have you lost or gained 10 pounds in the last 6 months? Yes No
25. Are you on a special diet and do not understand the diet? Yes No
26. Do you have a pressure ulcer (sore, red area or open skin) that won't heal? Yes No
If yes, where is it located & describe: _____
27. Describe your dairy (calcium) intake: _____
28. Describe your exercise routine:
- Types of exercise: _____
- Duration and frequency (ie. "20 minutes, 3 times/week): _____
29. How many hours of sleep do you average per night? _____ hours
30. What is your occupation? _____ Number of hours/week? _____
31. Do you receive regular Dental care? Yes No Eye care? Yes No
32. When was your cholesterol last checked? _____ Results: _____
33. When was your last Hemocult test for colon cancer screening (tests stool samples for blood)? _____
34. Have you ever had a Flexible Sigmoidoscopy test for colon cancer screening? Yes No
If yes, when? _____
35. Are you in a relationship where you are being threatened or hurt either emotionally, physically or sexually?
 Yes No If yes, describe: _____
36. Do you have any social, language, emotional or spiritual issues that you would like to discuss? Yes No
If yes, describe: _____
37. Do you have a health care directive? Yes No
If no, would you like information about making one? Yes No
38. According to health plans and insurance companies, a "complete physical exam" is designed to review health maintenance issues and not a time to address new or specific concerns. However, we would like you to list any current health concerns with the understanding that we may need to schedule future visits to appropriately address all issues: _____

Signature _____ Date _____



Knewton
Health Group

Patient Transfer Request

Date: _____

To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of my: X-Rays Records Other: _____
and request that they be sent to:

Knewton Health Group
23505 Smithtown Road Suite 100
Excelsior, MN 55331
952-470-8555

Name of Patient: _____

Signature: _____

Patient DOB: _____

Patient Address: _____
