Dr. Eddie Paulk, DO
Dr. Vamsi Nukala, MD
618-288-5430 Anderson Medical Group 618-288-6857
Internal Medicine of Maryville
2090 Vadalabene Drive. Maryville, IL 62062

Our primary care providers would like to welcome you to our office. We want your experience with our office to be a good one. If you have any questions, our staff is here to assist you.

Enclosed is paperwork that we are asking you to complete prior to your first visit to the office.

Please arrive 30 minutes early for your appointment and be sure to present your COMPLETED new patient paperwork to the front desk staff.

Please be sure to bring your insurance cards, a photo ID, co-payment if your insurance requires and a list of your current medications with you to your scheduled appointment.

The staff of Anderson Medical Group

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PATIENT REGISTRATION

Patient Last Name ________________________ **First Name** ____________________ **Middle Initial** ________

Address _________________________________ **City**_________________ **State** _______ **Zip** ___________

Home Phone __________________ **Work Phone** _________________ **Cell Phone** ____________________

Email address ___________________________________ **Fax** ___________________________

SS# ____________________________ **Date of Birth** ____________________ **Sex:** ☐**female,** ☐**male**

Marital Status ____________________

Employer Name ____ **Phone** _____________________________

Employer Address _______________________________ **City** _______________ **State** ______ **Zip** ________

Which is preferred phone number to call? ___Home, ___Work, ___Cell.

INSURANCE INFORMATION:

Primary Insurance

Insurance Name __________________________ **Policy #** ______________________ **Phone** _________________

Name of Insured ____ **Relationship** ___________________________

SS# ________________________ **Date of Birth** _______________________

Employer Name ____ **Phone** _____________________________

Employer Address _______________________________ **City** _______________ **State** ______ **Zip** ________

Secondary Insurance

Insurance Name __________________________ **Policy #** ______________________ **Phone** _________________

Name of Insured ____ **Relationship** ___________________________

SS# ________________________ **Date of Birth** _______________________

Employer Name ____ **Phone** _____________________________

Employer Address ______________________________ **City** _______________ **State** ______ **Zip** ________

Emergency Contact __________________________________ **Phone** _______________________________

I hereby authorize the providers of Anderson Medical Group to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and understand I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. I acknowledge receipt of the Notice of Privacy Practices for Anderson Medical Group.

____

Signature of Patient/Authorized Person **Date**

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Last Name ___________________________ First Name ___________________________ Date of Birth _____________

Medication List

List your prescribed drugs, inhalers and over-the-counter drugs and vitamins

Name of Drug	Strength	Frequency

Allergies to medications

Name of Drug	Reaction

Surgery

Surgery	Year

Chronic Health Problems check all that apply

☐Allergies ☐Anemia ☐Anxiety ☐Arthritis
☐Asthma ☐Blood Clots ☐Cancer________________ ☐Cardiac Arrhythmia
☐COPD ☐Congestive Hearth Failure ☐Coronary Artery Disease ☐Crohns/Colitis
☐Depression ☐Diabetes ☐Gallbladder disorder ☐GERD/Acid Reflux
☐Headaches/Migraine ☐Heart Disease ☐Heart Attack ☐Hypertension
☐Irritable Bowel Syndrome ☐Kidney Disease ☐Osteoporosis ☐Seizures
☐Stroke ☐Thyroid Disorder ☐other__________ ☐other_____________

Family Health History:

List all health problems each experienced and indicate if deceased, the age and cause of death.

	Age	Cause
Mother____	___	___________
Father____	___	___________
Paternal Grandmother____	___	___________
Paternal Grandfather____	___	___________
Maternal Grandmother____	___	___________
Maternal Grandfather____	___	___________
Siblings____	___	___________

Health Maintenance:

Flu Vaccine:	☐Yes ☐No	Date________
Tetanus Vaccine:	☐Yes ☐ No	Date________
Shingles Vaccine:	☐Yes ☐No	Date________
Pneumonia Vaccine: Type_______________	☐Yes ☐No	Date of Dose #1________Dose #2_________
Complete Physical Exam:	☐Yes ☐No	Date________
Adults over 20 Cholesterol:	☐Yes ☐No	Date________
Adults over 50 Colonoscopy:	☐Yes ☐No	Date________
Females over 21 Pap Smear:	☐Yes ☐No	Date________
Females over 50 Mammogram:	☐Yes ☐ No	Date________
Females over 65 Bone Density Scan:	☐Yes ☐ No	Date________
Males over 50 Prostate Exam:	☐Yes ☐No	Date________

FEMALE PATIENTS ONLY

Are you pregnant? ☐YES ☐NO

Number of pregnancies: ___________ Miscarriages: _________Terminated Pregnancies: _______Live Births: ________

Date of last menstrual cycle: ___________ Usual length of cycle: ___________ Days of flow: ___________

Usual menstrual cycle: Regular Irregular Painful/Cramps

Birth Control Method: ____

If menopausal, do you experience any symptoms? ☐YES ☐NO

Date of last PAP test: ____ Normal Abnormal

Date and Facility of last Mammogram: _________________________________ Normal Abnormal

How often do you perform Self Breast Exams? ____

MALE PATIENTS ONLY

Any urinary complaints? (hesitation in starting urine stream, decrease in force or flow, dribbling)

How many times per night do you awaken to urinate? ____

Any difficulty in getting or maintaining an erection? ☐YES ☐NO

Have you had a PSA blood test? ☐YES ☐NO

Date of PSA: ________________________ Normal Abnormal

Medical History

<u>In the Past have you experienced any of the following: (Circle if Yes)</u>

CHEST PAIN; SWOLLEN FEET; DIFFICULTY BREATHING; HEARTBURN; DIFFICULTY SWALLOWING;

CHANGE IN BOWELS; BLOOD IN URINE OR STOOL; TROUBLE CONTROLLING URINE OR STOOL;

PAINFUL JOINTS; SWOLLEN JOINTS; FAINTING SPELLS; DIZZINESS; NUMBNESS; WEAKNESS;

GET HOT EASILY; GET COLD EASILY; SKIN OR HAIR CHANGES; EXCESSIVE DAYTIME DROWSINESS;

SNORING; DIFFICULTY SLEEPING; OVERLY TIRED; IRRITABLE; CRYING; CHRONIC COUGH;

PROLONGED SADNESS; WEIGHT CHANGE; RASH; VISION CHANGE; MEMORY LOSS; BRUISING;

COUGHING UP BLOOD; EXCESSIVE BLEEDING; SEXUAL DYSFUNCTION; LEG PAIN WITH WALKING;

PALPITATIONS; EXCESSIVE THIRST; VOMITING; FREQUENT URINATION; ABDOMINAL PAIN; ANEMIA

<u>Chronic Health Conditions (circle all that apply)</u>

HEART PROBLEMS; HIGH BLOOD PRESSURE; HIGH CHOLESTEROL; RHEUMATIC FEVER;

DIABETES OR HIGH BLOOD SUGAR; ASTHMA; TB; ULCERS; HEPATITIS; JAUNDICE; STROKE;

MIGRAINES; SEIZURES; HEAD TRAUMA; LOSS OF CONSCIOUSNESS; BREAST LUMPS;

BLOOD TRANSFUSION; CANCER; HIV/AIDS; KIDNEY DISEASE; ILLEGAL DRUG USE

Health Habits and Safety

Do you exercise? ☐YES ☐NO How frequently? ___________ What type? ___________________________

Any difficulty with sleep? ☐YES ☐NO Describe:____

- **Caffeine** ◻ None ◻Coffee ◻Tea ◻Cola _____ # of cups/cans per day?
- **Alcohol** Do you drink alcohol? ◻Yes ◻No
  If yes, what kind?____________ Amount and frequency_______________
  Are you concerned about the amount you drink? ◻Yes ◻No
- **Tobacco** Do you use tobacco? ◻Yes ◻No
  ◻Cigarettes – pks./day____ ◻Chew - #/day____ ◻Pipe - #/day____ ◻Cigars - #/day____◻ Vaping___
  ______# of years ______ and/or year quit. Tried to quit? ◻Yes ◻No

Do you take any street drugs? ☐YES ☐NO What type? _________________________________

Care Team (Name of Specialists involved in your care):

Doctor's Name	Specialty	Contact Information

Pharmacy Information: Provide as much information as possible.

Name: ____

Address:____

Phone:____

Secondary Pharmacy: ____

Name:____

Address:____

Phone:____

Signature: ____ Date: ______________________________

ANDERSON MEDICAL GROUP
Eddie Paulk, DO
2090 Vadalabene Drive.
Phone: 618-288-5430 Fax: 618-288-6857

Information is to be released FROM:
____
____
____
Phone: _________________________

Patient Identification:
____
(Printed Name)
____
(Date of Birth)
__XXXX-XX-________________
(Last 4 of Social Security Number)

Information is to be released TO:
EDDIE PAULK, DO
2090 VADALABENE DR
MARYVILLE, IL 62062
618-288-5430

Information to be Released Covers the Time Frame

From Date: __________ To Date: ___________

Please check the type of information to be released. ☐ Employee View Only Access Check Here

☐ Final Diagnosis	☐ X-ray Reports	☐ Mammogram with Report
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History / Physical	☐ EKG	☐ Emergency Record
☐ Consultation Reports	☐ Pathology Reports	☐ ENTIRE RECORD
☐ Operative Reports	☐ Progress Notes	☐

This information is being requested for the following purpose (s):

☐ Treatment or Consultation	☐ At the request of the patient	☐ Billing or Claims payment
☐ Comparison to Current Mammogram	☐ Other:	

I understand that:

- I may inspect and copy the information that I authorized to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above Attention Release of Information—Health Information Management Department.
- My refusal to consent to the use or disclosure of the above-mentioned information will prevent the disclosure of the information.
- If not revoked this authorization will expire 180 days from the date signed or ___________________(date expires).
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA. However this information will continue to be protected by Illinois Law.
- I understand by signing this release, **if applicable**, ***HIV/aids or genetic information, drugs/alcohol and /or mental health records*** **will be included.** (Check NO below if you do not want this information released.)

☐ NO. Specify the information NOT to be released: ____

By signing below, you authorize the release of your protected health information specified as above. I also understand that I will not be denied treatment if I do not provide authorization to use or disclose protected health information.
A copy of the signed authorization will be provided.

____ ______________________
Signature of patient or personal representative Date signed

____.
If not signed by the patient, specify reason for signing, and relationship

____ ______________________.
Signature of witness to above signing Date Signed