KEVIN M. KUREY, M.D., PC
101 Regency Park Drive, Suite 130
McDonough, Georgia 30253
(770) 957-3935

The purpose of this form is to help us to get prompt payment from your insurance company. Please print all of the requested information carefully so that we can read it.
Thank you for helping us to help you!

Today's Date: _____/_____/_____

Section 1 – Patient Information

Patient's Name: ______________________ Social Security #: ______-______-______
Address: ______________________ Home Phone: (____) ______-______
City, State, Zip: ______________________ Work Phone: (____) ______-______
Birth Date: ____/___/___ Age: ________ Sex: ____________ Marital Status: ______________
Employment Status(Full-time,Part-time,Retired,Unemployed,Student–full/part time): ______________
Employer's Name: ______________________
Employer's Address: ______________________
Employer's City, State, Zip: ______________________
Known allergies to medications: ______________________

Section 2 – Person Responsible for Bill (if other than patient)

Relationship to patient: ______________________
Name: ______________________ Social Security # ______-______-______
Address: ______________________ Home Phone: (___) ______-______
City, State, Zip: ______________________ Work Phone: (___) ______-______
Birth Date: _____/___/______ Age: __________ Sex: __________ Marital Status: ______________
Employment Status (full time, part time, retired, unemployed, full/part-time student): ______________
Employer's Name: ______________________
Employer's Address: ______________________
Employer's City, State, Address: ______________________

Section 3 – Primary Insurance

Insurance Co.: ______________ Policy No: ______________ Group No: ______________
Address: ______________________ Phone: (___) ______-______
City, State, Zip: ______________________
Insured's Name: ______________________ Home Phone: (___) ______-______
Insured's Address: ______________________ Work Phone: (___) ______-______
Insured's City, State, Zip: ______________________
Birth Date: _____/______/_____ Age: _________ Sex: __________ Marital Status: ______________

KEVIN M. KUREY, M.D., PC
101 Regency Park Drive, Suite 130
McDonough, Georgia 30253
(770) 957-3935

Section 4 – Secondary Insurance

Insurance Co:______________________________Policy No:__________________________ Group No:__________________
Address:____Phone: (___) ________-____________________
City, State, Zip:____
Insured's Name:____Home Phone: (___) ___________-____________
Insured's Address:____Work Phone: (___) ___________-____________
Insured's City, State, Zip:____
Birth Date:_____/______/_______ Age: _________ Sex:__________ Marital Status:________________

Section 5 – Agreements

1. Financial Responsibility: I understand that I am financially responsible for payment for all charges for services rendered to the patient named in Section 1, including any balance remaining after payment of any insurance benefits, and any contractually required adjustments.

Signature of Person Responsible:____________________________________Date:____/____/_______

2. Assignment: I authorize assignment of all insurance benefits for medical services rendered to me from Kevin M. Kurey, M.D., PC.

Signature of Patient:____Date:____/____/_______

3. Record Release: I authorize the release of any medical information necessary to process insurance claims on my behalf.

Signature of Patient:____Date:____/____/_______

Section 6 – Uncovered Service Waiver

Each patient is required to present a proof of coverage at the time of service. If coverage should prove not to be in effect on the date of service, or if the service provided is excluded by the insurance company, then Kevin M. Kurey, M.D., PC, will bill and hold responsible the guarantor of this account for all services, whether covered by insurance or not.
*Note: Most insurance does not pay for adult routine physicals or more than 12 visits a year.

Signing below states you understand the necessary requirements:

____ ________/______/_______
Signature of Responsible Party Date

Section 7 – Missed Appointments

It is understood that all broken appointments without prior notice are subject to a $25 charge that will be billed directly to the patient.

____ ________/______/_______
Signature of Responsible Party Date

Medical History

Date ___________

Name ______________________ Age _____ Birthdate __________
Address ______________________ Sex ☐ Male ☐ Female
______________________ Home Phone _______________
______________________ Work Phone _______________
Occupation ___________________ Emergency Contact ___________
Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If married, spouse's name ______________________________________
Children's names and ages ______________________________________

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

____________ ____________ ____________ ____________
____________ ____________ ____________ ____________
____________ ____________ ____________ ____________
____________ ____________ ____________ ____________

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Skin diseases
☐ Heart Disease	☐ T.B.	☐ Gall Bladder disease	☐ Blood disorders
☐ Chest pain/chest tightness	☐ Hay Fever	☐ Colitis	☐ Anxiety
☐ Shortness of breath	☐ Abdominal discomfort	☐ Hepatitis or Jaundice	☐ Depression
☐ Swollen Ankles	☐ Indigestion	☐ Thyroid disease	☐ Anemia
☐ Palpitations	☐ Nausea	☐ Head or neck radiation	☐ Alcohol abuse
☐ Lightheadedness	☐ Vomiting	☐ Headache	☐ Drug abuse
☐ Frequent urination	☐ Constipation	☐ Kidney disease	☐ Gout
☐ Rheumatic fever	☐ Diarrhea	☐ Kidney Stones	☐ Impotence or Erectile Dysfunction
☐ Asthma	☐ Blood in stool	☐ Difficulty urinating	☐ Ulcers
☐ Other			

____
____
____
____
____

This information is for use by your physician as part of your confidential medical record.

Medical History

Date ___________

Name ______________________________

Gynecologic and Obstetric History

Age at onset of periods ___________ Frequency ____________________ Length of period ________________

Pregnancies ____________________ Births ________________________ Miscarriages ___________________

Prolonged or abnormal bleeding ☐ No ☐ Yes (please describe) ______________________

Leakage of urine ☐ No ☐ Yes (please describe) ______________________

Pelvic pain ☐ No ☐ Yes (please describe) ______________________

Abnormal discharge ☐ No ☐ Yes (please describe) ______________________

History of abnormal Pap smear ☐ No ☐ Yes (please describe) ______________________

Please List and Supply the Dates of:

Operations ____________________ ______________________ ______________________

____________________ ______________________ ______________________

Hospitalizations other than for surgery ______________________ ______________________

____________________ ______________________ ______________________

Immunization history-have you had:

Hepatitis B? ☐ No ☐ Yes When ________

Other? ☐ No ☐ Yes When ________

Pneumovax immunization? ☐ No ☐ Yes When ________

Flu immunization? ☐ No ☐ Yes When ________

Tetanus immuniz ation? ☐ No ☐ Yes When ________

When was your last:

Pap Smear? ____________ Breast Exam? ____________ Stool check for blood? ____________

Mammogram? ____________ Cholesterol check? ____________ Prostate exam? ____________

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had any of the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)	______________________	__________
Hypertension (high blood pressure)	______________________	__________
Heart Disease	______________________	__________
Diabetes	______________________	__________
Strokes	______________________	__________
Mental disease (anxiety, depression, etc)	______________________	__________
Drug or alcohol addiction	______________________	__________
Glaucoma	______________________	__________
Bleeding diseases	______________________	__________
Other	______________________	__________

Medications (Prescription, Over-the-Counter, Vitamins, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

This information is for use by your physician as part of your confidential medical record.

Medical History

Date ___________

Name ___________________________

Prevention

Question	Response	Follow-up	
Do you wear seat belts?	☐ Yes ☐ No	If no, why not?	____________________
Do you wear a bike helmet?	☐ Yes ☐ No	☐ N/A	___________________
Do you exercise regularly?	☐ Yes ☐ No	If yes, type, duration and number of times per week?	___________________
Do you smoke?	☐ Yes ☐ No	If yes, how many packs per day?	___________________
Do you drink alcoholic beverages?	☐ Yes ☐ No	If yes, how much per week.	___________________
Do you drink coffee?	☐ Yes ☐ No	If yes, how many cups per day?	___________________
Do you drink tea?	☐ Yes ☐ No	If yes, how many cups per day?	___________________
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ Yes ☐ No	If yes, explain:	___________________
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes ☐ No	☐ N/A	___________________
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ Yes ☐ No	If yes, explain	___________________
Do you wish to be tested for AIDS?	☐ Yes ☐ No		
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ Yes ☐ No	If yes, explain.	___________________
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ Yes ☐ No		
Do you ever feel afraid of your partner?	☐ Yes ☐ No	☐ N/A	
Do you have a "living will"?	☐ Yes ☐ No		____________________
Do you have a donor card?	☐ Yes ☐ No		____________________
Method of birth control?	____		

This information is for use by your physician as part of your confidential medical record.

Kevin M. Kurey, M.D., PC

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Kevin M. Kurey,M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Kevin M. Kurey's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kevin M. Kurey, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kevin M. Kurey, M.D. Privacy Officer at 101 Regency Park Drive, Suite 130, McDonough, Georgia. 30252.

With this consent, Kevin M. Kurey, M.D. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Kevin M. Kurey, M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Kevin M. Kurey, M.D. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Kevin M. Kurey, M.D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Kevin M. Kurey's use of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kevin M. Kurey, M.D. may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____________________________________	________________________
Patient's Name	Date

____
Print Name of Patient or Legal Guardian