KWAK FAMILY MEDICINE,PC

Where Your Family's Health Is Protected

Patient Registration Form

Today's Date:_____

Last Name: _____ Social Security #: _____

First Name: _____MI: _____ Gender: M ____ F ____

Marital Status: __Single __Married __Widowed __Separated __Divorced __Other Date of Birth: _____

Employment Status:__Employed __Unemployed __Disabled __Homemaker __Student __Active Military __Self-Employed __Other

Race (Optional):

__African-American __Asian __European/Caucasian __Arab__Jewish __Hispanic (non-euro) __Native American __Multi-Racial __ Other

Home Address: _____ Home Phone: (____)_____

City, State, Zip: _____ Cell Phone: (____)_____

Email Address: _____ Work Phone: (____)_____

Work Address: _____ Driver's License #: _____

City, State, Zip: _____ State of License: _____

Emergency Contact:_____

Relationship to Patient : _____ Best Phone # for Emergency Contact: (____)_____

Previous Primary Care Physician: _____ Doctor's Phone #: (____)_____

Dr.'s Address: _____ Doctor's Fax #: (____)_____

<u>No Show Policy:</u> (Please initial to confirm that you have read this policy). <u>If I miss an appointment, without calling to cancel*at least 6 hours in advance*, I agree to pay the required $25 No Show Fee.</u>

Initial Here: _____

<u>Test Results Phone Call:</u> May we call you to communicate test results to you? ___Y ___N

If yes, which phone numbers can we call? _____

May we leave a message? ___Y ___N

<u>Guarantor Info:</u>Please complete *if guarantor is other than self*. Guarantor is the person financially

responsible for this patient's bill.

Guarantor:	_____	Relationship to Pt:	_____
Address:	_____	Social Security #:	_____
City, State, Zip:	_____	Date of Birth:	_____
Employer:	_____	Gender:	M ____ F ____
Address:	_____	Home Phone:	(____)_____
City, State, Zip:	_____	Cell Phone:	(____)_____
Driver's Lic. #:	_____	Work Phone:	(____)_____
State of License	_____	E-mail:	_____

Insurance Info: If your visit is regarding auto insurance, you'll need to fill out an additional form before being seen.
Please see the front desk to request this form.

Primary Carrier:	_____	Subscriber's Name:	_____
Address:	_____	Date of Birth:	_____
City, State, Zip:	_____	Gender:	M ____ F ____
Telephone #:	(_____) _____	Relationship to Pt:	_____
ID #:	_____	Social Security #:	_____
Group/Plan #:	_____	Effective Date:	_____
Second Carrier:	_____	Telephone #:	(____)_____
Address:	_____	Subscriber's Name:	_____
City, State, Zip:	_____	Date of Birth:	_____
ID#:	_____	Gender:	M ____ F ____
Group/Plan #:	_____	Relationship to Pt:	_____
Effective Date:	_____	Social Security #:	_____

Medical History:

Reason for today's visit:

_____

Past and present medical problems:

_____

_____

Past hospitalizations:

_____

Past surgeries:

_____

Past procedures:

_____

Medicines:

_____

Allergies to medicines/foods/environments:

_____

Any history of anaphylaxis (life threatening allergic reaction)? ___Y ___N If yes, to what?

_____

Are you a smoker? ___Y ___N How much do you smoke a day? _____

Do you drink? ___Y ___N ___Y How much do you drink? ___Y ___N

Daily ___N

?

Do you use any illegal substances including marijuana? ___Y ___N What substance(s)? _____

Religious beliefs that affect your health?

_____

Family History:

Father:_____Mother:_____

Please list major medical issues Siblings:

_____

Consents:

A.*Use of photograph*y: I understand that my photographs may be taken for the purposes of medical treatments or for chart identification purposes at KFM only.

B. *Assignment of benefits/authorization/notice of collection practices*: I request payment of insurance benefits for all services rendered to me or to my child/children to be made on our behalf to KFM. I authorize KFM to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due. These amounts may include annual deductibles, co-payments, and charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action (e.g. late fees, collection agency, court or attorney costs). Please be advised our office may contact you via an automated system regarding appointments

and/or account status. I agree that this authorization shall remain valid unless/until I rescind in writing.

C. *HIPAA Notice of Privacy Practices*: I have read KFM's HIPAA Notice of Privacy Practices and give my consent for KFM to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations.

D. *Payment Policy/Practice Philosophy*: I have read KFM's payment policy and practice philosophy and agree to abide by them.

E. *Email Communication & Patient Portal Services*: I understand that by giving my email address to KFM I may be contacted by email for appointment reminders. When it becomes possible to communicate with KFM via email or via KFM's internet patient portal, I give my permission to give and receive information related to my health through those electronic means.

I certify that I have read and understood the above statements (A-E) and have agreed to abide by the terms and conditions.

Patient Name (please print): _____

Patient's Signature: _____ Date: _____

Patient's Agent Representative/Guarantor/Parent Signature: _____ Date: _____

<u>Medicare Consent:</u> (FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to KFM for any services furnished to me by KFM. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Is there Medigap coverage secondary to Medicare?	___Y ___N	Are you or your spouse employed?	___Y ___N
Are you covered under the Black Lung Program?	___Y ___N	Do you or your spouse have other insurance?	___Y ___N
Are you disabled or have end stage renal disease?	___Y ___N	Has treatment been authorized by the V.A.?	___Y ___N
Is there insurance coverage primary to Medicare?	___Y ___N	Is illness/injury the result of an auto accident?	___Y ___N
Is there employer supplemental coverage secondary to Medicare?	___Y ___N	Did illness/injury occur at work?	___Y ___N

I certify that I have read and understood the above statements and have agreed to abide by the terms and conditions.

Patient Name (please print): _____

Patient's Signature: _____ Date: _____
or
Patient's Agent Representative/Guarantor/Parent Signature: _____ Date: _____