Kwak Family Medicine, PC (KFM)

Patient Registration Form

Today's Date: _____

Last Name: _____ Social Security Number: _____
First Name: _____MI: ____ Date of Birth: _____ Gender: M__F__
Marital Status: Single__Married__Widowed__Separated__Divorced__Other__
Home Address: _____ Home Phone: (_____)_____
City, State, Zip: _____ Cell Phone: (_____)_____
Email address: _____ Work Phone: (_____)_____
Employment status: Employed__Unemployed__Disabled__Homemaker__Student__Active military__ Self-employed__Other__
Email address: _____ Driver's License #_____
Work Address: _____ State____
City, State, Zip: _____
Race (optional): African-American__Asian__European(Caucasian)__Arabic__Jewish__Hispanic(non-euro)__Native-American__Multi-racial__Other__
Emergency contact: _____ Relationship to patient:_____
Best no. to reach this emergency contact: (_____)_____
Previous PCP: _____ Phone no. to previous PCP: (_____)_____
Address of previous PCP: _____
Fax to previous PCP: _____

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor:_____ Relationship to patient:_____
Address:_____ Social Security Number:_____
_____ Date of Birth:_____ Sex: M__F__
City, State, Zip:_____ Home Phone:(____)_____
Employer:_____ Cell Phone:(____)_____
Address:_____ Work Phone:(____)_____
_____ E-mail:_____
City,State,Zip:_____ Driver's License #_____State___

INSURANCE INFORMATION (if your visit is regarding auto insurance, you'll need to fill out an additional form, please inquire about the form at the front desk prior to being seen.)

Primary Carrier:_____ Telephone:(____)_____
Address:_____ ID #:_____
_____ Subscriber's Name:_____
Group/Plan#:_____ Relationship to patient:_____
Effective Date:_____ Subscriber's SSN:_____
Subscriber's DOB:_____ Sex: M__F__

Secondary Carrier:_____ Telephone:(____)_____

Address:_____ ID#:_____

_____ Subscriber's Name:_____

Group/Plain#:_____ Relationship to patient:_____

Effective Date:_____ Subscriber's SSN:_____

Subscriber's DOB:_____ Sex: M__F__

MEDICAL HISTORY

Reason for today's visit:_____

_____

_____

Past and present medical problems:_____

_____

Past hospitalizations:_____

Past surgeries:_____

Past procedures:_____

Medicines:_____

_____

Allergy to medicines/foods/environments:_____

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

Are you a smoker? Yes__No__ How much do you smoke a day?_____

Do you drink? Yes__No__ Daily?Yes__No__ How much do you drink?_____

Do you use any illegal substance including marijuana? Yes__No__ What?_____

Family history: Father_____Mother_____

Siblings_____

Religious beliefs that affect your health? _____

CONSENTS

A. Use of photograph

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/Noticeof 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 I am responsible to pay certain amounts due. These amounts may include annual deductibles, co-payments, 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 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 ready KFM's payment policy and practice philosophy and agree to abide by them.

E. Medicare (if applicable)

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: (for Medicare patients only)

Are you or your spouse employed? Y__N__

Do you or your spouse have other insurance? Y__N__

Are you disabled or have end stage renal disease? Y__N__

Is illness/injury the result of an auto accident? Y__N__

Did illness/injury occur at work? Y__N__

Has treatment been authorized by the V.A.? Y__N__

Are you covered under the Black Lung Program? Y__N__

Is there Medigap coverage secondary to medicare? Y__N__

Is there insurance coverage primary to Medicare? Y__N__

Is there employer supplemental coverage secondary to Medicare? Y__N__

F. Email Communication & Patient Portal Services

I understand that by giving my email address to KFM that I may be contacted by email for appointment reminders. When it becomes possible to communicate with KFM via email or via KFM's patient portal through internet, 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 A through F statements and have agreed to abide by the terms and conditions.

Patient Name (please print): _____

Patient Signature: _____ Date:_____

Patient's Agent Representative and Guarantor (including parent) Signature:

_____ Date: _____

TEST RESULT PHONE CALLS

May we call you to communicate test results to you? If yes, please write down the phone number(s) and what phone(s) they are is (i.e. home, cell, work, etc.)

_____

May we leave a voicemail if you don't pick up the call? Y__N__