KIM MEDICAL GROUP

A. PATIENT INFORMATION

SOCIAL SECURITY # ______________________________

FIRST NAME ____________________ MIDDLE __________

LAST NAME ______________________________

SEX ________ DATE OF BIRTH ______/______/______

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ MINOR

OF CHILDREN: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ Other ________

RACE ____________________

PREFERRED LANGUAGE ______________________________

HOW DID YOU HEAR OF US? ______________________________

HOME ADDRESS ______________________________

CITY ________________ STATE ______ ZIP __________

EMAIL ______________________________

HOME PHONE (_______)______________________________

CELL PHONE (_______)______________________________

EMPLOYER NAME ______________________________

WORK PHONE (_______)______________________________

WORK ADDRESS ______________________________

CITY ________________ STATE ______ ZIP __________

I GIVE PERMISSION TO LEAVE MESSAGES REGARDING MY HEALTH INFORMATION AT: ☐ HOME ☐ CELL ☐ BOTH

B. INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

**** PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST ****

C. EMERGENCY CONTACT

FIRST NAME ____________________ MIDDLE __________

LAST NAME ______________________________

SEX ________ RELATIONSHIP TO PATIENT ______________

HOME PHONE (_______)______________________________

CELL PHONE (_______)______________________________

Do you have an Advance Healthcare Directive? ________

Would you like information? ____________________

D. ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ **and assign directly**
Name of Insurance Company(ies)
to Kim Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Print Name of Patient, Parent, Guardian or Personal Representative

____
Date

____
Relationship to Patient

Kim Medical Group
Initial Patient Health History

Patient Name: ________________________ **Birthdate:** ___ / ___ / _____ **Age:** ____ **Date:** ____ / ____ / _____

What is the reason for your visit? ____

1. Patient History

Have you ever, or do you presently have any of the following conditions? If so, please indicate when you were diagnosed, and the treatments and/or surgeries received for the conditions.

Hypertension: ________________________________
Diabetes: ________________________________
Heart disease: ________________________________
Asthma, lung disease: ________________________________
Cataract: ________________________________
Tuberculosis: ________________________________
Stomach/bowel problems: ________________________________
EGD: ________________________________
Colonoscopy: ________________________________

Hepatitis, liver disease: ________________________________
Kidney disease: ________________________________
Depression, Mental illness: ________________________________
Spinal disease, osteoporosis: ________________________________
Arthritis: ________________________________
Thyroid disease: ________________________________
Cancer: ________________________________
Stroke: ________________________________
Other: ________________________________

2. Family History

If any of your family has had any of the following conditions, please indicate the age at which he/she was diagnosed.

	Heart disease	Stroke	Diabetes	Hypertension	High cholesterol	Cancer	Mental illness	Other
Father								
Mother								
Siblings								
Other relatives								

3. Social History

Do you smoke? No Yes (If so, how many packs per day? ____ For how many years? ______)
If you are a former smoker, when did you stop smoking, how many packs per day did you smoke, and for how many years did you smoke? ________________________________
Do you drink alcohol? No Yes (If so, approximately how many drinks per week? ______)
Have you ever used recreational/street drugs? No Yes
Do you exercise regularly? No Yes (If so, how many hours per week do you exercise? _______
What kind of exercise? ________________________________)

4. Immunizations

Td / Tdap No Yes, Date: ____/____/_______
Hepatitis B No Yes, Date: ____/____/_______
Pneumovax No Yes, Date: ____/____/_______
Zostavax No Yes, Date: ____/____/_______
Other: ____________________________

5. Allergies & Medications

Do you have any allergies due to medication, x-ray, and/or other substances? No Yes, ____________________________
Please list all medications you are currently taking including prescription drugs, vitamins, over-the-counter medications, herbs, etc.

Medication	Dosage & Directions	Medication	Dosage & Directions
1. __________________	___________	5. __________________	___________
2. __________________	___________	6. __________________	___________
3. __________________	___________	7. __________________	___________
4. __________________	___________	8. __________________	___________

Patient Signature: ________________________________ **Date:** ____ / ____ / __________

KIM MEDICAL GROUP

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45CFR Parts 160 and 164)

1. I hereby authorize Kim Medical Group to use and/or disclose the protected health information described below to

____
[Name of Person(s) and Relationship]

____
[Name of Person(s) and Relationship]

____
[Name of Person(s) and Relationship]

2. Authorization for Release of Information. Covering the period of health care from
□ ___________ to ____________ **OR** □ all past, present and future periods:

a. □ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse and financial).

OR

b. □ I hereby authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): ____

3. This authorization shall be in force and effect until __________________, at which time this authorization expires.
[Date]
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_______________________________________ _______________________
Signature of Patient or Personal Representative Date

_______________________________________ _______________________
Print Name of Patient or Personal Representative Relationship to Patient

Kim Medical Group
2500 Alton Parkway, Suite 108, Irvine, CA 92606
(949) 552-8282

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: ______________________________ Date: ___________________________

Print Name: __________________________ Telephone: ______________________

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

To our patients:

Thank you for visiting Kim Medical Group.

We would like to notify you of a situation that could arise when you have blood drawn or biopsies done in our clinic.

We take blood samples and perform biopsies in our clinic; however, we send the samples to the laboratory, and the lab runs the actual tests. Our office sends the claim to the insurance company for the procedure, but it is the lab that sends the claim to the insurance company for the testing of the samples.

Other than what the insurance company has paid to the lab, it is the patient's responsibility to pay the remaining portion if it applies to the patient's deductible or coinsurance. This bill must be paid directly to the lab.

Kim Medical Group is not responsible for any bills that are sent to the patient from the laboratory. Any questions regarding laboratory bills should be directed to the laboratory. Please be advised that any payments that are not rendered to the laboratory could be detrimental to your credit.

If you have any questions regarding the above content, please ask us before any tests are performed.

Thank you.

I acknowledge the above content.

Patient Name: ____

Patient Signature: ____

Date: ____

KIM MEDICAL GROUP
Medication Refill Policy

We receive many phone calls each day in regards to medication refill requests, which take valuable staff and physician time to address. Thus, we have changed our medication refill policy. We understand that this is a change for both you and us, and ask for your understanding. Your cooperation with this policy will allow us to provide you with quality clinical care.

Please plan ahead!

1. At the time of your appointment, you will be provided with a sufficient amount of routine medication until your next scheduled appointment. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in denial of refills.
2. If you think you will run out of your medication prior to your scheduled appointment, please **contact your pharmacy** at least **THREE** days before your medication is due to run out. If you use a mail-order pharmacy, please contact them at least **FOURTEEN** days before your medication is due to run out. Your pharmacy will then contact us by fax, phone, or electronic request to inform us that you are in need of a refill.
3. Any medications that are not taken on a daily basis (i.e. antibiotics) usually require an office visit for evaluation.

If you have any questions or concerns, please ask the receptionists at the front desk. Thank you.

Patient Name: ____

Patient Signature: _____________________________________ **Date**: ___ /___ /______