KWAK FAMILY MEDICINE,PC

Where Your Family's Health Is Protected

Patient Registration Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: _____ Social Security #: _____

Marital Status: __Single __Married __Widowed __Separated __Divorced __Other

Employment Status: __Employed __Unemployed __Disabled __Homemaker __Student __Military __Self-Employed __ Retired __Other

Race (optional): __Black/African American __Asian __White/Caucasian __Arab __Jewish __Hispanic __Hawaiian/Pacific Islander __Native American __Multi-Racial __Other

Home Address: _____ Cell Phone: (_____)_____

City, State, Zip: _____ Home Phone: (_____)_____

Work Address: _____ Work Phone: (_____)_____

City, State, Zip: _____

Email Address: _____

Emergency Contact: _____

Relationship to Patient: _____ Emergency Contact Number: (_____)_____

Previous Primary Care Physician: _____

Dr.'s Address: _____

Doctor's Phone: (_____)_____ Doctor's Fax: (_____)_____

Preferred Pharmacy Name and Location/Zip Code: _____ Pharmacy Phone: (_____)_____

No Show Policy: If I miss an appointment without calling to cancel/change that appointment during office hours the day(s) before, or the Friday before Monday appointments, I agree to pay the required $30 No Show Fee. We do not accept weekend cancellations. This will be due at the time of your next appointment. After two No Shows, I will be asked to find a new primary care physician.

Test Results: May we text you to communicate test results via our secure, HIPAA compliant text messaging system? _____Y _____N

Which phone numbers can we text (include any other approved names/contacts)? _____

_____

Insurance Info:

Primary Carrier: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Gender: M ____ F ____

ID #: _____ Group/Plan #: _____

Address: _____

City, State, Zip: _____

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

Guarantor: _____ Relationship to Pt: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Employer: _____

Medical History:

Reason for today's visit: _____

_____

Past and present medical conditions: _____

_____

_____

Past hospitalizations: _____

_____

Past surgeries or procedures: _____

_____

Medications: _____

_____

_____

Allergies to medicines/foods/environments: _____

_____

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

Do you smoke? _____Y _____N How much do you smoke a day? _____

Do you drink? _____Y _____N How much do you drink?_____day/week/month (circle)

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

Religious beliefs that affect your health/treatment? _____

Family Health History: *Please list major medical issues.*

Father:_____

Mother:_____

Siblings: _____

Grandparents: _____

Consents:

A. Use of photography: 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.

F. Refills & Follow-up Appointments: I understand that in order to receive routine medication refills I am expected to schedule a follow up appointment every 3-6 months depending on the medication. Please give us **24-28 hours' notice** for any refill requests.

G. Forms/Letter policies: Forms or letters takes an average of 7 business days for Dr. Kwak to complete. We will contact you once Dr. Kwak completes it. These forms or letters require a fee depending on the document.

H. No Show Policy: If I miss an appointment without calling to cancel/change that appointment during office hours the day(s) before, I agree to pay the required **$30 No Show Fee**. We do not accept weekend cancellations. This will be due at the time of your next appointment. After two No Shows, I will be asked to find a new primary care physician.

I certify that I have read and understood the above statements (A-H) 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: _____

Medicare Consent (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 (A-F) and have agreed to abide by the terms and conditions.

Patient Name (please print): _____

Patient's Signature: _____ Date: _____

or

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

KWAK FAMILY MEDICINE,PC

Where Your Family's Health Is Protected

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www.kwakfamilymedicine.com

REQUEST FOR RELEASE OF RECORDS

I request that my records be released from:

Facility/Hospital Name: _____

Date(s) of Service: _____

Facility/Hospital Phone: _____ Fax: _____

to Kwak Family Medicine, PC

Date: _____

Patient Name: _____ DOB: _____

Reason for Request: _____

Patient/Guardian Signature:_____

New Jersey Department of Health
Vaccine Preventable Disease Program

P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)

CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number