Chong S Kim, MD
ENT and Facial Plastic Surgeon

100 Commons Way, Suite 701
Holmdel, NJ 07733
Phone: 732-796-0182
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300 Perrine Rd., Suite 301
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Today's Date_____

PATIENT INFORMATION

*Please Print Patient's Complete Legal Name

Patient's Name _____

Address _____

City, State, Zip _____

Patient's E-Mail Address_____ Web Enable YES or NO

Home Tel: ( ) _____-_____ Cell Tel: ( ) _____-_____ Marital Status_____

Birth Date_____ Age_____ Sex_____ Social Security #_____-_____-_____

Referred to Our Office by_____ Phone: ( ) _____- _____

Primary Care Physician_____ Phone: ( ) _____ - _____

Patient's Employer_____Occupation_____

Employer Tel: ( ) _____ - _____Employer Address _____

Spouse's Name _____Spouse's Work # ( ) _____ - _____

Next Of Kin _____ Relationship_____ Phone: ( ) _____- _____

BILLING INFORMATION

Policy Holder's Name _____ **Date of birth** _____

S.S. #_____ - _____ - _____ **Relationship to Patient** _____

Billing Address (if different from above) _____

_____

Patient's Height_____ Patient's Weight_____

Flu Vaccine Yes or No, If Yes, date_____

Pneumonia Vaccine Yes or No If yes, date_____

Do you have or have you had:

Diabetes	Y	N
Hypertension	Y	N
Stroke	Y	N
Cancer	Y	N
Ulcers	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
Angina	Y	N
Heart Failure	Y	N
Emphysema	Y	N
Pneumonia	Y	N
TB	Y	N
Arthritis	Y	N
Kidney Disease	Y	N
HIV / AIDS	Y	N
Hepatitis	Y	N
Bleeding Disorder	Y	N
Asthma	Y	N
Thyroid Disease	Y	N

Please list current medications:

_____

_____

_____

Please list allergies and type of reactions:

_____

_____

_____

Please list past surgical procedures:

_____

_____

_____

Please list previous diagnostic tests, (pertaining to eyes, nose or throat) X-RAYS, CT SCANS, Etc.

_____

_____

_____

Special History:

Do you smoke? Y N

How much? _____

How long? _____

Drink Alcohol? Y N

How much? _____

How long? _____

Please list environmental or food allergies:

_____

_____

Pharmacy Name and # _____

Has anyone in the family suffered from:

Hearing Loss	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Lung Disease	Y	N
Fever with anesthesia	Y	N
Bleeding Disorders	Y	N

Complete Family History:

Are your parents alive?

Father YES NO

Mother YES NO

How many siblings / children do you have?

Brother (s) _____

Sister (s) _____

Son (s) _____

Daughter (s) _____

Are they healthy Y N

If no, Explain _____

Reason for Appointment: _____

Review of Systems:
(Circle items that apply to you)

General: Change in appetite / fatigue

Eyes: Vision changes / dry eyes / excessive tearing / blurring / double vision / cataract

Ears: Hearing loss / ringing / pain / discharge / dizziness

Nose: Sinus problem / breathing difficulty / nose bleed / loss of smell

Throat: Pain / voice change / hoarseness / coughing blood

Heart: Chest pain / shortness of breath upon exertion / shortness of breath at night / palpitation

Lungs: Coughing / wheezing / shortness

Gastrointestinal: Indigestion / heartburn / swallowing difficulty / pain on swallowing / abdominal pain / Diarrhea / constipation / bloody stool

Genitourinary: Difficulty with urination / pain on urination / blood in urine / incontinence

Hematologic: Easy bruising / bleeding tendency / low blood count

Skin: Rash / mole / lump / sore / eczema

Endocrine: Excessive thirst / frequent urination / cold or heat intolerance / weight loss / weight gain

Musculoskeletal: Joint pain or swelling / back pain / arm or leg problems

Neurologic: Numbness / tingling / weakness / fainting / seizure / dizziness / tremor

Psychiatric: Emotional disturbance / depression / drug or alcohol problem

Females Only:

Vaginal Bleeding Y N

Date of last period _____

Are you pregnant Y N

Dr. Kim is also a facial plastic surgeon. Would you be interested in Dr. Kim discussing with you various facial cosmetic and laser services that may be of interest to you? ***Y N***

I authorize the release of any medical information necessary to process my insurance claim

PATIENT'S SIGNATURE

_____Date_____

(Parent or Guardian if patient is a minor)

I hereby assign payment of benefit from my insurance company to Chong Kim, PA, but not to exceed the reasonable and customary charges for these services.

INSURED'S SIGNATURE

_____Date_____

So that we can better identify your needs, please take a moment to fill out this questionnaire. We greatly appreciate you time.

How good is your hearing? Would you be interested in having your hearing tested? ***YES NO***

Listening Situations	Hearing Quality					Importance to You		
	Poor				Normal	Not	Somewhat	Very
Television	1	2	3	4	5	1	2	3
Leisure Activities	1	2	3	4	5	1	2	3
Restaurants	1	2	3	4	5	1	2	3
Church	1	2	3	4	5	1	2	3
Meetings/Groups	1	2	3	4	5	1	2	3
Female Voice	1	2	3	4	5	1	2	3
Male Voice	1	2	3	4	5	1	2	3

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CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's date of Birth: _____ **Patient's SSN #** _____-_____-_____

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights to you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your consent by giving written notice to our **Privacy Officer**. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To be completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent form and the Notice Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's signature or Signature of Patient's representative Date

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Andrew Kim

Practice address: 100 Commons Way, Suite 701
Holmdel, NJ 07733

Phone: 732-796-0182 Fax: 732-796-0186

Financial Policy

Credit Card Payments:
We accept cash, checks, Visa, MasterCard, Discover, and AMEX. The minimum amount for credit card payment is $60.00. Any amount less than $60.00 there will be a $5.00 fee added to the transaction.

Co-Payments/Co-Insurance/Deductibles:
Your insurance company requires us to collect co-payments, co-insurance and/or deductible at the time of service. Waiver of the patient's financial obligation constitutes fraud under state and federal regulations. Pursuant to these laws, the practice cannot and will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility. If you are not able to pay your obligation, you may reschedule your appointment or may choose to be billed for a fee of $5.00.

Referrals:
It is the patient's responsibility to understand their insurance. If your insurance requires a referral, a valid insurance referral must be presented at the time of your visit. Failure to do this will cause your visit not to be covered by your insurance, and you will be responsible for the full amount of your visit.

Billing Charges:
A charge of $5.00 per billing statement will be assessed for any unpaid co-payments, co-insurance, deductible, and all outstanding balances beyond the first statement.

Non-Covered and Out of Network Services:
Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Appointment Cancellations & No-Shows:
We understand that there are times when you must miss an appointment due to an emergency or obligations due to work or family. We require 24 hour notice to cancel office appointments. If you fail to cancel your appointment with us, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If you fail to give our office 24-hour's notice, you will be charged a $40.00 fee (for regular) or $150 fee (for procedure) appointments.

Surgery Cancellation:
Any patient who fails to arrive for their surgery or cancels surgery two weeks prior to the scheduled appointment date will be charged a fee of $250.00.

Delinquent Balance:
Patients with a delinquent balance are required to make a payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understood, and agreed to the provisions of this Patient Financial Policy Form:

Patient's Signature **Date**