KEN PARK MD INTERNAL MEDICINE

Date: _____

Patient Demographic

Full Name:_____**Date of Birth:**_____/_____/_____**SSN:** _____

Address:	City:
State: Zip:	Home #:
Cell #:	Work #: Ext:
Email:	
Marital Status: ▫ Married 0 Single 0 Divorced 0 Widowed	
Emergency Contact Name: Relation:	Phone #:

Primary Insurance:

Insurance Carrier:	Insurance Phone #:
Member ID:	Group #:
Effective Date:	Policy Holder Name:
Policy Holder DOB:	Policy Holder SSN:
Policy Holder Relationship to Patient:	

Secondary Insurance:

Insurance Carrier:	Insurance Phone #:
Member ID:	Group #:
Effective Date:	Policy Holder Name:
Policy Holder DOB:	Policy Holder SSN:
Policy Holder Relationship to Patient:	

Preferred Pharmacy:_____**Phone:** _____

Address:_____Fax:_____

City State Zip

How did you hear about us? _____

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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Full Legal Name:_____ Gender: ▢ M ▢ F Date: _____

DOB: _____ Age: _____ Phone#: _____ Date of Last Physical Exam: _____

PERSONAL HEALTH HISTORY

Childhood Illness: ▢ Measles ▢ Mumps ▢ Rubella ▢ Chickenpox ▢ Rheumatic Fever ▢ Polio

Immunizations & Dates: Tetanus _____ Pneumonia _____ Chickenpox _____

Influenza _____ MMR _____ Hepatitis _____

Past and Present Medical Problems

▢ High blood pressure	▢ Heart attack	▢ High cholesterol	▢ Stroke/TIA
▢ Heart failure	▢ Atrial fib/arrhythmia	▢ Diabetes	▢ Kidney disease
▢ Thyroid disease	▢ Cancer	▢ Coagulopathy/Clotting disorder	

Other Past/Present Medical History not listed: _____

_____

Surgery/Hospitalizations/Reason	Year

Allergy	Reaction You Had

Please list ALL medications, over-the-counter medications, vitamins, diet supplements, herbal supplements

Medication/Reason	Dosage/Frequency	Medication/Reason	Dosage/Frequency

HEALTH HABITS

Exercise: ▢ Sedentary/None ▢ 1-2x/wk for 30min ▢ 3-4x/wk for 30min ▢ More than 5x/wk for 30min
Diet: Are you dieting? ▢ YES ▢ NO If yes, what diet?
Caffeine: ▢ None ▢ Coffee ▢ Tea ▢ Cola ▢ Energy Drink # of cups/cans per day?
Alcohol: Do you drink alcohol? ▢ YES ▢ NO If yes, what kind and how many drinks per wk?
Tobacco: Do you use tobacco? ▢ YES ▢ NO If yes, what kind and how often per wk? _____ If former user: Year quit:_____ # of years: _____
Drugs: Do you use recreational drugs? ▢ YES ▢ NO If yes, what kind and how often per wk? _____ If former user: Year quit:_____ # of years: _____
Sex: Are you sexually active? ▢ YES ▢ NO If yes, are you trying for pregnancy?
Personal Safety: Do you live alone? ▢ YES ▢ NO Do you have an Advance Directive/Living Will? ▢ YES ▢ NO Do you have vision/hearing loss? ▢ YES ▢ NO Do you have frequent falls? ▢ YES ▢ NO

FAMILY HEALTH HISTORY - *please list:*

Father _____

Mother _____

Siblings _____

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____ Period every_____days

Is menstruation heavy, irregular, spotting, pain, discharge? ▢ YES ▢ NO Any hot flashes/sweating at night? ▢ YES ▢ NO

Any recent breast tenderness, lumps, or nipple discharge? ▢ YES ▢ NO Are you pregnant or breastfeeding? ▢ YES ▢ NO

Any problems controlling urination? ▢ YES ▢ NO Pain w/urination? ▢ YES ▢ NO

Any urinary tract, bladder, kidney infections w/in last year? ▢ YES ▢ NO

Date of last pap smear exam: _____

MEN ONLY

Any problems controlling urination? ▢ YES ▢ NO Pain w/urination? ▢ YES ▢ NO

Any prostate, bladder, kidney infections w/in last year? ▢ YES ▢ NO

REVIEW OF SYSTEMS (please circle if you have any of the following)

•CONSTITUTIONAL•	**•CARDIOVASCULAR•**	**•RESPIRATORY•**
Fatigue / Drenching night sweats	Ankle swelling / varicosities	Asthma / Wheezing
Fever / Chills	Calf pain with / without exercise	COPD / Pneumonia / Emphysema
General health excellent / poor	Chest pain with exertion / exercise	Coughing / Coughing up blood
Unexplained weight loss / gain	Chest pain / Heart murmur	Shortness of breath on exertion
	Irregular / Rapid heart rate	Obstructive sleep apnea
•EYES•	Leg pain / Cramping in leg at night	
Glasses / Contacts / Blindness		**•EARS/NOSE/MOUTH/THROAT•**
Blurry vision / Double vision	**•GASTROINTESTINAL•**	Hearing loss / Ringing in ears
Cataracts / Macular degeneration	Abdominal pain	Prolonged nosebleeds
Glaucoma / Retinopathy	Bloating / Diarrhea / Constipation	Dentures / Difficulty swallowing
Partial loss of vision / Blind spots	Blood in stool / Black or tarry stool	**•NEUROLOGICAL•**
	Loss of appetite / Heartburn	Migraines / Headache / Vertigo
•MUSCULOSKELETAL•	Nausea / Vomit	Tingling / Numbness
Artificial knee / hip joint	Ulcer disease / Pain after eating	Seizures
Back pain / Joint pain	Vomit blood	
Muscle pain / Weakness / Cramps		**•ENDOCRINE•**
Rheumatoid Arthritis		Cold / Heat intolerance
Osteoarthritis	**•HEME / LYMPHATIC / IMMUNE•**	History of drug resistant infection
	Anemia / Low platelet count	**•PSYCHIATRIC•**
•GENITOURINARY•	Bleeding disorder / Easy bleeding	Anxiety / Depression
Incontinence / Difficulty voiding	Easy bruising	Confusion / Memory loss
Kidney stones	Lymphoma / Leukemia	Difficulty sleeping
Urgency / Blood in urine	Impotence	Suicidal ideation / attempt

KEN PARK MD INTERNAL MEDICINE

Authorization to Release Medical Information

Patient Name: _____ Date: _____

Date of Birth: _____ Phone #: _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

City State Zip

Reason for Request:_____ Date(s) of Treatment: _____

Information to be Released or Accessed:

0 All Records	0 Consultation Reports	0 Immunizations
0 Clinic Notes	0 EKG Reports	0 Medication/Prescription List
0 Procedure Notes	0 Radiology Reports	0 Problem List
0 Lab/Pathology Reports	0 Radiology Images	0 Other_____
0 Behavioral Health		

This information may be disclosed and used by the following individual or organization:

Release To: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

City State Zip

Method of Delivery:

0 Fax #: _____

0 Mail to address listed above or other: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that the treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for companies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:_____.

X_____ **X**_____

Printed Name of Patient Date

X_____ **X**_____

Signature of Patient or Guardian Relationship to Patient

KEN PARK MD INTERNAL MEDICINE

General Care for Consent and Treatment Consent

Welcome to Ken Park MD, PLLC. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides Ken Park MD, PLLC with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with Ken Park MD, PLLC about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request Ken Park MD, PLLC, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily.

X_____

Printed Name of Client or Guardian

X_____

Date

X_____

Signature of Client or Guardian

X_____

Relationship to Client

KEN PARK MD INTERNAL MEDICINE

Patient Financial Responsibility and Authorization Form

1. Individual's Financial Responsibility
    - I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered services.
    - Co-payments are due at the time of service.
    - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. Insurance Authorization for Assignment of Benefits

    I hereby authorize and direct payment of my medical benefits to Ken Park MD, PLLC on my behalf for any services furnished to me by the providers.

3. Authorization to Release Records

    I hereby authorize Ken Park MD, PLLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. Medicare Request for Payment

    I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Ken Park MD, PLLC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Acknowledgement:

I certify that the above information is true and correct to the best of my knowledge. I understand the importance of current information and know it is my responsibility to keep this office informed of any changes in my insurance or personal information. I realize any claims that are denied or delayed due to this information not being updated are my responsibility. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

By signing below, I verify the information above is correct and true.

X_____
Printed Name of Client or Guardian

X_____
Date

X_____
Signature of Client or Guardian

X_____
Relationship to Client

KEN PARK MD INTERNAL MEDICINE

HIPAA Privacy Notice Acknowledgement

Ken Park MD PLLC is required by law to keep your health information and records safe.
This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

- I acknowledge that I have received a copy of Ken Park MD PLLC HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
- I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.
- I understand Ken Park MD PLLC cannot disclose my health information other than as specified in the notice.
- I understand that Ken Park MD PLLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

I authorized the following (please check):

- ☐ I consent to receiving any and all medical documents pertaining to myself via my personal email address I have provided.
- ☐ I consent to receiving any and all medical updated and information pertaining to myself via telephone.

X_____ **X**_____

Printed Name of Client or Guardian — Date

X_____ **X**_____

Signature of Client or Guardian — Relationship to Client

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s):

_____ _____

Signature — Date