KEN PARK MD INTERNAL MEDICINE

Date (날짜): _____

Patient Demographic (환자 정보)

Full Legal Name (이름)**:**_____**SSN** (사회보장번호)**:** _____

Date of Birth(생년월일) **:**_____/_____/_____ **Gender** (성): ▫ M(남) ▫ F(여)

Address (주소):	City (도시):
State (주): Zip (우편번호):	Home # (집):
Cell (휴대폰):	Work # (직장): Ext:
Email(이메일):	
Marital Status (혼인 상태): ▫ Married (기혼) ▫ Single (미혼) ▫ Divorced (이혼) ▫ Widowed (사별)	
Emergency Contact (비상 연락망) Name (이름) : Relation (관계) :	Phone # (전화번호):

Primary Insurance (주 보험**)** :

Insurance Carrier (보험사) :	Insurance Phone # (보험 전화번호):
Member ID (회원ID) :	Group #:
Effective Date (시작일):	Policy Holder Name (보험계약자 이름):
Policy Holder DOB(보험 계약자 생년월일):	Policy Holder SSN (보험 계약자 SSN):
Policy Holder Relationship to Patient (보험 계약자와의 관계):	

Secondary Insurance(부 보험**):**

Insurance Carrier (보험사):	Insurance Phone #(보험 전화번호):
Member ID (회원ID):	Group #:
Effective Date (시작일):	Policy Holder Name (보험 계약자 이름):
Policy Holder DOB(보험 계약자 생년월일):	Policy Holder SSN(보험 계약자 SSN):
Policy Holder Relationship to Patient(보험 계약자와의 관계):	

Preferred Pharmacy (선호하는 약국**) :**_____**Phone (**약국 전화번호**) :** _____

Address (약국 주소): _____ Fax (팩스 번호):_____

*City(*시*)* *State(*주*)* *Zip (*우편번호*)*

KEN PARK MD INTERNAL MEDICINE

Health History Questionnaire (건강 이력 질문지)

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

Full Legal Name (성, 이름) :_____ Gender(성): ▫ M(남) ▫ F(여) Date(날짜): _____

DOB(생년월일): _____ Age(나이): _____ Phone#(전화번호): _____

PERSONAL HEALTH HISTORY (개인 건강 이력)

Childhood Illness (유년기 질병):

0 Measles(홍역) ▫ Mumps(이하선염) ▫ Rubella(풍진)

0 Chicken pox(수두) ▫ Rheumatic Fever(류마티스열) ▫ Polio (소아마비)

Immunizations & Dates(예방접종 및 날짜) :

Tetanus(파상풍) _____ Pneumonia(폐렴) _____ Chickenpox(수두) _____

Influenza(독감) _____ MMR(홍역-이하선염-풍진) _____ Hepatitis(간염) _____

Past and Present Medical Problems (과거 및 현재 건강 문제)

0 High blood pressure (고혈압) 0 Heart attack(심근경색) 0 High cholesterol(고 콜레스테롤)

0 Stroke/TIA(뇌졸중) 0 Heart failure (심부전) 0 Atrial fib/arrhythmia(심방세동/부정맥)

0 Diabetes (당뇨) 0 Kidney disease(신장 질환) 0 Thyroid disease (갑상선 질환)

0 Cancer (암) ▫ Coagulopathy/Clotting disorder(응혈이상/응고장애)

Other Past/Present Medical History not listed (위에 작성되지 않은 과거 및 현재의 질환)

:_____

Surgery/Hospitalizations/Reason (수술/입원/이유)	**Year(연도)**

Allergy (알러지)	**Reaction You Had (알러지 반응)**

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

모든 의약품, 의약외품, 비타민, 다이어트 보충제, 허브 보충제를 적어주세요.

Med/Reason (약/이유**)**	**Dosage/Frequency (**복용량/주기**)**	**Med/Reason(**약/이유**)**	**Dosage/Frequency(**복용량/주기**)**

HEALTH HABITS (건강 습관**)**

Exercise (운동**):** ▫ Sedentary/None (거의 안함) ▫ 1-2x/wk for 30min (주 1-2회 30분)
0 3-4x/wk for 30min (주 3-4회 30분) ▫ More than 5x/wk for 30min(주 5회 이상 30분)

Diet (식단**)**: Are you dieting? (다이어트 하시나요?) ▫ YES(예) ▫ NO(아니오)
If yes, what diet? (예라면, 어떤 다이어트를 하시나요?)

Caffeine (카페인**):** ▫ None(없음) ▫ Coffee(커피) ▫ Tea(차) ▫ Soda(음료) ▫ Energy Drink(에너지 음료)
# of cups/cans per day? 하루에 몇 컵 또는 캔을 드시나요?

Alcohol (알코올**):** Do you drink alcohol?(알코올을 드시나요?) ▫ YES (예) ▫ NO(아니오)
If yes, what kind and how many drinks/wk? (예라면, 어떤 종류의 알코올을 주에 얼마나 자주 마시나요?)

Tobacco(담배**):** Do you use tobacco? (담배를 피우시나요?) ▫ YES (예) ▫ NO (아니오)
If yes, what kind and how often per wk?(예라면, 어떤 종류의 담배를 주에 얼마나 자주 피시나요?) _____
If former user(금연하신 경우): Year quit:_____ # of years: _____

Drugs(마약**)**: Do you use recreational drugs? (기분전환용 마약을 하시나요?) ▫ YES ▫ NO
If yes, what kind and how often per wk?(예라면, 어떤 종류의 마약을 주에 얼마나 하시나요?) _____
If former user (중단하신 경우): Year quit(중단 연도):_____ # of years (연도 수): _____

Sex(성관계**):** Are you sexually active? (성관계 하시나요?) ▫ YES (예) ▫ NO (아니오)
If yes, are you trying for pregnancy? (예라면, 임신을 시도를 하고 계신가요?) _____

Personal Safety(개인의 안전**):**
Do you live alone? (혼자 사시나요?) ▫ YES (예) ▫ NO (아니오)
Do you have an Advance Directive/Living Will? (사전지시/생전 유서가 있나요?) ▫ YES (예) ▫ NO (아니오)
Do you have vision/hearing loss? (시력/청력에 손실이 있나요?) ▫ YES (예) ▫ NO (아니오)
Do you have frequent falls? (자주 넘어지나요?) ▫ YES (예) ▫ NO (아니오)

FAMILY HEALTH HISTORY(가족 건강 이력**)** - *please list:*

Father (아버지) _____

Mother (어머니) _____

Siblings (형제자매) _____

WOMEN ONLY (여성분만 작성해주세요**)**

Age at onset of menstruation (월경 시작한 나이): _____ Date of last menstruation(마지막 월경일): _____

Period every (월경주기)_____days (일) Date of last pap smear exam (최근 자궁경부 검사일): _____

Is menstruation heavy/irregular/spotting/pain/discharge? (생리 과다/불순/부정출혈/통증/냉이있나요?) ▫ YES (예) ▫ NO (아니오)

Any hot flashes/sweating at night? (밤에 열감이나 땀이 나나요?) ▫ YES (예) ▫ NO (아니오)

Are you pregnant or breastfeeding? (임신 중이거나 모유수유 하시나요?) ▫ YES (예) ▫ NO (아니오)

Any recent breast tenderness/lumps/nipple discharge? (최근 유방 압통/혹/유두 분비가 있었나요?) ▫ YES (예) ▫ NO (아니오)

Pain w/urination? (비뇨통이 있나요?) ▫ YES (예) ▫ NO (아니오)

Urinary tract/bladder/kidney infections w/in last year? (일년 내 요로/방광/신장에 감염이 있었나요?) ▫ YES(예) ▫ NO (아니오)

Any problems controlling urination? (비뇨 조절에 문제가 있나요?) ▫ YES (예) ▫ NO (아니오)

MEN ONLY (남성분만 작성해주세요**)**

Any problems controlling urination? (비뇨 조절에 문제가 있나요?) ▫ YES (예) ▫ NO (아니오)

Pain w/urination? (비뇨통이 있나요?) ▫ YES (예) ▫ NO (아니오)

Any prostate, bladder, kidney infections w/in last year? (일년 내 요로/방광/신장에 감염이 있었나요?) ▫ YES (예) ▫ NO (아니오)

REVIEW OF SYSTEMS (기관 점검**)** (please circle if you have any of the following) (해당되는 곳에 동그라미 치시오)

⬩**CONSTITUTIONAL** (체질)⬩	⬩**CARDIOVASCULAR** (심혈관)⬩	⬩**RESPIRATORY** (호흡)⬩
Fatigue / Drenching night sweats (피로/땀으로 젖음)	Ankle swelling / varicosities (발목 부음 / 정맥류)	Asthma / Wheezing(천식/천명)
Fever / Chills (열/오한)	Calf pain with / without exercise (종아리 통증, 운동할 때 / 안할 때)	COPD / Pneumonia / Emphysema (만성폐쇄성폐질환/폐렴/폐기종)
General health excellent / poor (일반적 건강 좋음 / 안좋음)	Chest pain with exertion / exercise (운동으로 인한 가슴 통증)	Coughing / Coughing up blood (기침/객혈 기침)
Unexplained weight loss / gain (알 수 없는 체중 감량 / 증가)	Irregular / Rapid heart rate (불규칙/빠른 심박수	Obstructive sleep apnea (폐쇄성 수면 무호흡증)
⬩**EYES** (눈)⬩	Chest pain / Heart murmur(가슴 통증/심장 잡음)	Shortness of breath on exertion(짧은 호흡)
Glasses / Contacts / Blindness (안경/렌즈/실명)	Leg pain / Cramping in leg at night (다리 통증/다리 경련)	⬩**EARS/NOSE/MOUTH/THROAT**⬩ (귀/코/입/목)
Blurry vision / Double vision (흐리게 / 여러개로 보임)	⬩**GASTROINTESTINAL** (위장)⬩	Hearing loss / Ringing in ears (청력 상실/이명)
Cataracts / Macular degeneration (백내장/황반변성)	Ulcer disease / Pain after eating (궤양 질환/식후 통증)	Prolonged nosebleeds (지속되는 코피)
Glaucoma / Retinopathy (녹내장/망막증)	Bloating / Diarrhea / Constipation (복부팽만/설사/변비)	Dentures / Difficulty swallowing (틀니/삼키기 어려움)
Partial loss of vision / Blind spots (부분적 실명/맹점)	Blood in stool / Black or tarry stool (혈변/흑색변)	⬩**NEUROLOGICAL** (신경)⬩
⬩**MUSCULOSKELETAL**⬩ (근골격)	Loss of appetite / Heartburn (식욕부진/속쓰림)	Migraines / Headache / Vertigo (편두통/두통/현기증)
Artificial knee / hip joint (인공 무릎/엉덩이 관절)	Nausea / Vomit (메스꺼움/토함)	Tingling / Numbness (얼얼함/무감각)
Back pain / Joint pain (요통/관절통)	Abdominal pain (복통)	Seizures (발작)
Rheumatoid Arthritis (류마티스 관절염)	Vomit blood (피를 토함)	⬩**ENDOCRINE** (내분비)⬩
Muscle pain / Weakness / Cramps (근육통/근력저하/근육 경련)	⬩**HEME / LYMPHATIC / IMMUNE**⬩ (혈액/림프/면역)	Cold / Heat intolerance (감기/열과민증))
Osteoarthritis (퇴행성 관절염)	Anemia / Low platelet count (빈혈/저혈소판 수)	History of drug resistant infection (내성 감염 이력)
⬩**GENITOURINARY**⬩ (비뇨-생식)	Bleeding disorder / Easy bleeding (출혈장애/출혈이 잘 남)	⬩**PSYCHIATRIC** (정신의학)⬩
Incontinence / Difficulty voiding (요실금/비뇨 곤란)	Easy bruising (멍이 잘 듬)	Anxiety / Depression (불안/우울)
Kidney stones (신장 결석)	Lymphoma / Leukemia (림프종/백혈병)	Confusion / Memory loss (혼란/기억상실)
Urgency / Blood in urine (급뇨, 혈뇨)	Impotence (발기 부전)	Difficulty sleeping (불면증)
		Suicidal ideation / attempt (자살 생각/시도)

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_____
Printed Name of Client or Guardian

X_____
Date

X_____
Signature of Client or Guardian

X_____
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