Kirkland Spinecare

New Patient Registration Form

Personal Information

Full Name: ______________________ Gender: **M** **F**
First *M.I.* *Last*

Address: ______________________
Street Address *City* *State* *ZIP Code*

Home Phone: ______________________ Cell Phone: ______________________

E-mail Address: ______________________ Best # to reach you: **Home** **Cell** **Other**

Social Security Number: **--** ______________________ Birth Date: ______________________

Marital Status: **Married** **Single** **Separated** **Divorced** **Widowed**

Who Referred You to our Office? ______________________

Reason for today's Visit: ______________________ Were you Injured? **Yes** **No**

If Injured, Date: ______________________ Place: ______________________ Nature of Injury: ______________________

If Injured, are you currently working: **Yes** **No** If not, last day worked: ______________________

Any Hospitalization: **Yes** **No** Hospital Name: ______________________

Admitted Date & Time: ______________________ Released Date & Time ______________________

Job Information

Occupation: ______________________ Employer: ______________________

Address: ______________________

Contact Name: ______________________ E-mail Address: ______________________

Work Phone: ______________________ Work Fax: ______________________

Spouse Information

Spouse's Name: ______________________ Birth Date:

Occupation: ______________________ Employer: ______________________

Address: ______________________ City, St Zip: ______________________

E-mail Address: ______________________ Cell Pone: **( )** ______________________

Work Phone: **( )** ______________________ Work Fax: **( )** ______________________

Emergency Contact Information

Full Name: ______________________
First *M.I.* *Last*

Primary Phone: **( )** ______________________ Alternate Phone: **( )** ______________________

Relationship: ______________________

Next Of Kin Information

Full Name: ______________________________
First *M.I.* *Last*

Primary Phone: ( ) ______________ Alternate Phone: ( ) ______________

Relationship: ______________________________

Primary Insurance Information

Insurance Company: ______________ Insurance Plan: ______________

Insurance ID#: ______________ Co-pay: ______________

Group Number: ______________ Group Name: ______________

Subscriber Name: ______________ Relationship to Patient: ______________
First *M.I* *Last*

Social Security Number: ______________ Birth Date: ______________

Secondary Insurance Information

Insurance Company: ______________ Insurance Plan: ______________

Insurance ID#: ______________ Co-pay: ______________

Group Number: ______________ Group Name: ______________

Subscriber Name: ______________ Relationship to Patient: ______________
First *M.I* *Last*

Social Security Number: ______________ Birth Date: ______________

I certify all the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kirkland Spinecare or insurance company to release any information required to process my claims.

______________________________ ______________
Patient/Guardian signature *Date*

______________________________ ______________
IF not signed by Patient, Guardian Name *Relationship to the patient*

If the patient is a minor or not legally competent, the parent or legal guardian must sign this document for the patient.

Patient Name: ________________________________

Please check all positive questions and write in any missing information

Review of Symptoms

- ☐ Blurry vision
- ☐ Chest pain
- ☐ Diarrhea
- ☐ Fever / Chill
- ☐ Headache
- ☐ Heart palpitation
- ☐ Heartburn / Reflux
- ☐ Insomnia
- ☐ Loss of appetite
- ☐ Loss of bladder control
- ☐ Loss of bowel
- ☐ Muscle ache / cramping
- ☐ Nausea / Vomiting
- ☐ Numbness in arm
- ☐ Numbness in leg
- ☐ Rash / Itching
- ☐ Ringing in the ear
- ☐ Significant weight gain/loss

______________________ ______________________ ______________________

Past Medical History

- ☐ Alcoholism/drug dependency
- ☐ Appendectomy
- ☐ Asthma
- ☐ Back surgery
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder surgery
- ☐ Head trauma
- ☐ Heart disease
- ☐ Heartburn
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Hysterectomy
- ☐ Kidney stone
- ☐ Migraine / headache
- ☐ Neck surgery
- ☐ Open heart surgery
- ☐ Other psychiatric illness
- ☐ Pace Maker placement
- ☐ Scoliosis
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcer

______________________ ______________________ ______________________

Family History

- ☐ Alcoholism/drug dependency
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Liver disease
- ☐ Neuropathy
- ☐ Seizure disorder
- ☐ Stroke

____

Medication (Dosage & Frequency):

______________________ ______________________
______________________ ______________________
______________________ ______________________

Drug Allergies (include reactions): ______________________________________
____

Miscellaneous

Cigarettes: ☐ (_____ packs/day X ____ yrs) Alcohol: ☐ (_____ drinks/day) Height: _________ Weight: _________

Have you received any (please circle): **Physical therapy** **Chiropractic care** **Massage** **Acupuncture**

List all other doctors you have seen for this condition: ______________________________________
____

Are you claustrophobic? **Yes** **No**

Any other pertinent information: ______________________________________
____

______________________________________ ______________________
Patient/Guardian signature *Date*

______________________________________ ______________________
IF not signed by Patient, Guardian Name *Relationship to the patient*

If the patient is a minor or not legally competent, the parent or legal guardian must sign this document for the patient.

Patient Name: ______________________________

ADVANCED BEBEFECIARY NOTICE (ABN) FOR MEDICARE P PATIENT

Medicare (pursuant to section 1832 (a) (1) of Medicare law) will pay for only services that they determine to be "reasonable and necessary". This notice is to inform you that some aspects of your medical care including (but not limited to) physical examination, X-rays and some other procedures, may be in your best interest and you and your health care provider may still request they be done. Our office will help you bill Medicare. However, should Medicare determine that these services are not "covered, reasonable or necessary" you will be responsible for the charges. For the purpose of this office, this includes, but not limited to, Physical examination, MRI, X-ray, Bone Scans, Laboratory testing, Lumbar Spinal Injection EMG and Nerve Conduction Studies and any procedure performed by the provider.

BENEFICIARY AGREETNT

I UNERSTDERSTAND THE ABOVE NOTICE. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR THE PAYMENT OF THE FULL BILL, INCLUDING LARBORATORY TESTING. I AM ALSO AWARE THAT THIS DOCUMENT IS VALID FOR ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW.

NOTE: AS A COURTESY TO OUR PATIENT WE WILL BILL YOUR SECONDARY INSURANCE ONLY ONCE FOR EACH VISIT.

____________________________________ ____________________

Signature Date

Patient Name: ______________________________

ADVANCED BENEFICIARY NOTICE (ABN) FOR NON-MEDICARE PATIENT

This notice is to inform you that some aspect of your medical care including (but not limited to) physical examination, X-rays, and some other procedures, may be in your best interest and you and your health care provider may still request they be done. Our office wi1l help you bill your Insurance. However, should your Insurance determine that these services are not 'covered', 'reasonable', or 'necessary' you will be responsible for the charges. For the purpose of this office, this includes, but not limited to, physical examination, MRI, X-ray, Bone Scans, Laboratory testing, Injections, EMG and Nerve Conductions Studies and any procedure performed by the provider.

BENEFICIARY AGREEMENT

I UNDERSTAND THE ABOVE NOTICE. IF MY INSURANCE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY REPONSIBLE FOR THE PAYMENT OF THE FULL BILL, INCLUDING LABORATORY TESTING. I AM ALSO AWARE THAT THIS DOCUMENT IS VALID FOR ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW.

NOTE: AS A COURTESY TO OUR PATIENTS WE WILL BILL YOUR SECONDARY INSURANCE ONLY ONCE FOR EACH VISIT.

____________________________________ ____________________

Signature Date

NOTICE OF PRIVACY PRACTICES

I, ___________________________________ confirm that the ***NOTICE OF PRIVACY PRACTICES*** was made available to me.

____ _________________________________

Patient or Legally Authorized Individual Signature Date

________________________________ ________________________________

Patient Name Relationship if signed on behalf of patient
(Parent, Legal Guardian, Personal Representative...)

Practice Policies

Cancellation Policy

Our schedule is always booked and we have no way to squeeze in any one who needs urgent care. We also noticed that some patients do not show up for their appointments or call at the last minute to cancel or reschedule. The situation is unfair to other patients who are trying to get in for urgent needs and for the provider.

Starting December 1, 2007, our office will start charging **$ 25.00** for any cancellation within 24 hours of the scheduled appointment and **$50.00** for no show.

I hope you can appreciate the situation. To avoid being charged, call our office to reschedule your appointment or cancel at least 24 hours ahead, thanks you for your understanding.

Co-Pay Policy

Co-pay is due at the time of service, it is your responsibility to know that you have one. We will be glad to bill you for your co-pay, however we will charge an additional fee for billing and administrative cost.

Cash Patients

All Discounts quoted on the Date of Service by Dr. Oh and/or his staffs apply only if patient pays the full amount for the date of service on the same day.

NO EXEPTIONS

If we need to bill for the visit, we will be glad to do so, however that negates the discount discussed by any of us.

Prescription Policy

Only certain prescriptions can be called in to the office. All other refill requests have to go through your pharmacy to be refilled. Please allow a minimum of 24 hours to 48 hours from the time you called it in to call and check on it.

________________________________ ________________________________

Patient Name Signature

Please sign to confirm you understand the above policies.