CONSENT TO RELEASE INFORMATION

This form is required in order to comply with federal HIPAA regulations.

Please understand that if this form is not filled out completely and accurately, then the information in your chart will *not* be given out to anyone. Failure to fill this form will also prevent your physicians from receiving progress notes in a timely manner.

Patient's Full Name ____________ Social Security Number ____________ Date of Birth ____________

1. A copy of my progress notes may be sent automatically to my referring physician.

Referring Doctor's Full Name (not ER doctors) ____________ Phone Number ____________

2. In addition, these physicians/institutions may access my progress notes upon request.

Primary Care Physician ____________ Phone Number ____________

Other Physician ____________ Phone Number ____________

Other Physician ____________ Phone Number ____________

3. Lastly, this institution may contact the following parties regarding my status.

Full Name ____________ Phone Number ____________ Relationship to Patient ____________

Full Name ____________ Phone Number ____________ Relationship to Patient ____________

Full Name ____________ Phone Number ____________ Relationship to Patient ____________

By signing below, I agree to all conditions stated above. I have read a copy of the HIPAA (Health Insurance Portability and Accountability Act) law, which went into effect April 2003. If I would like a copy of the HIPAA law, I may request it. This form will remain valid until I notify in writing that my progress notes no longer need to be sent to the parties mentioned above.

Patient's Signature (or Guardian) ____________ Date ____________

PATIENT REGISTRATION SHEET

Referring MD? ______________________________
First Name Last Name Ph No.

Primary Care Physician ______________________________
First Name Last Name Ph No.

Your legal name : ______________________ ______________________ ________
Last Name Full First Name MI

Age:____ SSN: __________ Sex: M F Marital Status: __________ Birth date:______________

Preferred Language: __________ Race:__________ Ethnicity:______________

Address: ____ Home Ph: ____________
CITY HI ZIP
Cell/Pager: ____________

EMPLOYER: ____________________ Occupation:________________ Work ph: ____________

Emergency Contact:__________________________________ Relationship to Patient: _________
Name Phone

Alternative Contact: ________________________________ Relationship to Patient: _________
Name Phone

If the patient is a child, who may authorize treatment for this child?

____ Relationship to Patient: _________
Name Phone

INSURANCE INFORMATION:

Primary Coverage: ____________________ Subscriber: ____________________
Membership/Sub #: ____________________ Subscriber DOB: ______________

Secondary Coverage: ____________________ Subscriber: ____________________
Membership/Sub #: ____________________ Subscriber DOB: ______________

Other Coverage: ____________________ Subscriber: ____________________
Membership/Sub #: ____________________ Subscriber DOB: ______________

Responsible Party Other Than Above

Please complete this section if someone other than the patient is responsible for payment of services:

Name: ____________________ Address: ______________________________
Bus. Ph: ____________ Home Ph: ____________ Relationship to patient: __________

Please read and sign below so that we may send your claims to your insurance company.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes. I authorize Kenneth Kaan, MD., its employees, Team-Praxis, to release to my insurance company, or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I understand that even though I have insurance coverage, I am responsible for payment of services rendered to the above mentioned patient. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Tricare, private insurance and any other health plan to Kenneth Kaan, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I will be assessed a bank interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Kenneth Kaan, MD and any of its employees to release all information necessary to secure payment and treatment.

____ ____________________
Signature of Responsible Party Date

Is this a Worker's Compensation or No-Fault Injury? _____ **Yes** _____ **No**

Patient's History Form

Name: ______________________ DOB: ____________ Date: ________

What is your primary complaint? ____

Date of onset of your problem? _____ - _____ - _____

Did you have a specific injury and if so describe its nature. ______________________

Allergies: Medication ______________________

Other ______________________

Height: _________ Weight: _________

Do you have aneurysm clips? Y N

Do you have a pacemaker? Y N

Do you have any metallic implants? Y N

Have you had metal in your eyes? Y N

Are you pregnant? Y N

Are you claustrophobic? Y N

Have you had brain surgery? Y N Year _____

Have you had heart surgery? Y N Year _____

Item: ______________________

Have you had a CAT scan before? Y N Where __________

Have you had an MRI before? Y N Where __________

What medications are you currently on?

Medication	Mg	Dose	Medication	Mg	Dose	Medication	Mg	Dose

Family history of illness: ______________________

Social Medical History

Do you or did you smoke cigarettes? Y N If yes, how many per day?______

Do you or did you drink alcohol? Y N If yes, how much per day?______

Past Medical History

Previous surgeries:

Type	Date	Type	Date

Do you suffer from:	Y	N		Y	N
Heart disease	_____	_____	Lung disease	_____	_____
Liver disease	_____	_____	Kidney disease	_____	_____
High blood pressure	_____	_____	Diabetes	_____	_____
Gout	_____	_____	Gastritis/Ulcer disease	_____	_____
Arthritic disorder	_____	_____	Bleeding disorder	_____	_____
Clotting disorder	_____	_____	Blood disease	_____	_____
Cancer	_____	_____	Infectious disease	_____	_____
Seizures/Convulsions	_____	_____	Abdominal pain		
Headaches	_____	_____	Nausea/vomiting		
Dizziness	_____	_____	Pain/Difficulty w/urine	_____	_____
Fainting spells	_____	_____	Blood in urine	_____	_____
Chest pains	_____	_____	Urinary incontinence	_____	_____
Shortness of breath	_____	_____	Cloudy urine	_____	_____
Palpitations	_____	_____	Fecal incontinence	_____	_____
Cough	_____	_____	Incomplete emptying of bladder	_____	_____
Constipation	_____	_____	Numbness/Tingling	_____	_____
Diarrhea	_____	_____	Weakness	_____	_____
Black/Red Stools	_____	_____	Reactions to anesthesia	_____	_____
			Family reaction to anesthesia	_____	_____

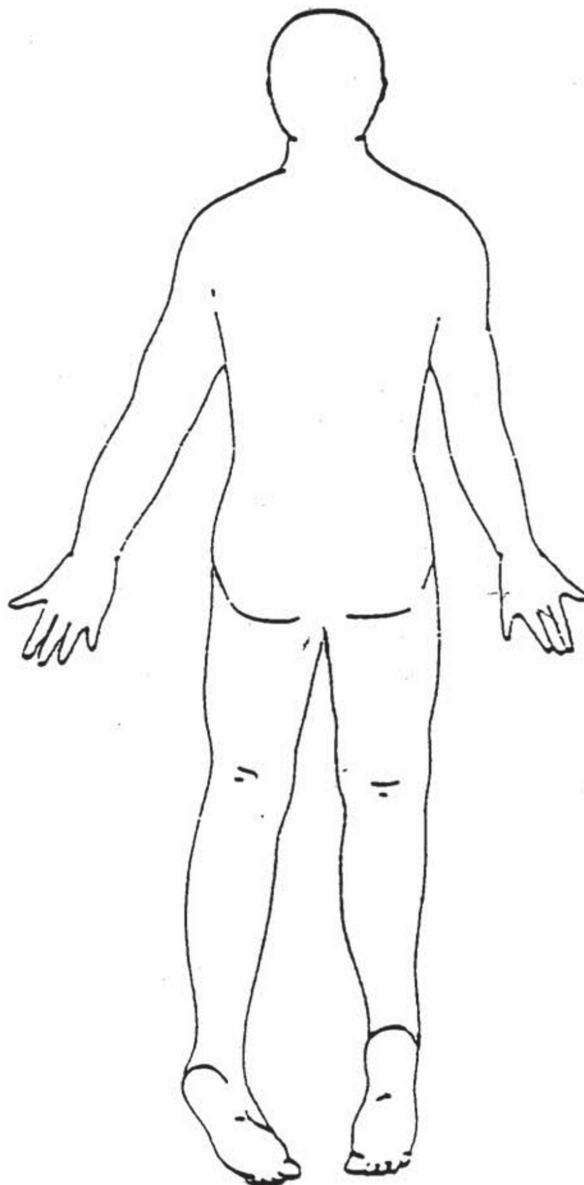
Name: ______________________________ DOB: ______________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

If you feel:

ACHE	use symbol	^ ^ ^ ^ ^ ^	BURNING	use symbol	x x x x x x
PINS & NEEDLES	use symbol	= = = = = =	STABBING	use symbol	/ / / / / /

BACK



FRONT