HENRY KAW M.D.
www.henrykawmd.com
321 N Pomona Ave Suite B Fullerton CA 92832
Phone (714) 462-8383
Fax (714) 462-8384

Date of Initial Visit
Referred by

Rev. 9.18.17

Patient Information						
Name		Preferred Name	[ ] Male [ ] Female	Social Security No.	Date of birth	Age
Cellphone ( )	Home Phone ( )	Work Phone ( )	Preferred method of communication: [] Cellphone [] Home [] Work [] Email			
Email address		[ ] I wish to sign up for online medical record access and appointment reminders			Preferred language	
Address		City	State	Zip Code	Ethnicity	

Insurance Information			
Guarantor : [] Self [] Spouse [] Child [] Other			
	Insurance Type	Insurance #	Date of Eligibility
Primary Insurance	[] PPO [] Medicare [] Caremore [] Medical [] CalOptima [] HMO - ( ) Prospect ( ) Regal /ADOC ( ) St Jude ( ) HCP/Arta		
Secondary Insurance			

Next of kin contact / Emergency contact Information			
Name		Relationship	
Address	City	State	Zip Code
Cellphone ( )	Home Phone ( )	Work Phone ( )	Preferred method of communication: [] Cellphone [] Home [] Work [] Email

Pharmacy Name	Address	Phone number

Prior and Current Doctors		
Prior Primary Care Physician (PCP):	Specialist/s and Specialty:	Specialist/s and Specialty:
Name	Name	Name
Address	Address	Address
Phone / Fax	Phone / Fax	Phone / Fax

I attest that all information above is true and accurate.
I give permission for Henry Kaw M.D. Inc., to bill my insurance for services rendered as my medical doctor.

I understand that I will be charged a **$50 cancellation fee** for appointments I fail to cancel within 24 hours.

Signature: _____ Date: _____

PLEASE HAND THIS PAGE TO THE FRONT DESK BEFORE PROCEEDING TO THE NEXT PAGE.

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Welcome and thank you for selecting us for your medical care. This information sheet provides an overview of our office policies. If you have questions regarding our policies, please approach one of our staff members.

INSURANCE AND BILLING

It is your responsibility to understand your insurance benefits. If you are not sure if a service or treatment is covered please contact your insurance carrier. We do not provide information about copayments, coinsurance, or deductible.

It is your responsibility to provide accurate insurance information to this office. Please present your valid insurance identification card(s) at the time of check-in. **Your copayment or coinsurance is required when you check-in.** If there is an additional balance due you will receive a bill from us. You are also responsible for payment of your deductible, and for charges not paid by your insurance carrier(s), which includes denied claims due to lack of information from the subscriber. If you do not have your insurance identification card and a photo ID, you will be asked to pay for your office visit or reschedule to another date. If we are unable to bill your insurance carrier because we did not receive your insurance information in a timely manner, you are responsible for the charges.

We accept many insurance plans. This means we will file your claim for you. This service is provided as a courtesy to you because we value your patronage. We will be happy to submit charges to any secondary or supplemental plans you may have, however, if payment is not received from that firm within 60 days we will issue a bill to you for payment in full.

If we do not accept your insurance plan, payment will be expected when services are rendered. You will be given a bill at time of checkout, which you may file with your insurance carrier for reimbursement. We will accept your payment in cash, check, Visa, and Mastercard.

There is a $50.00 fee for returned checks. 18% per annum interest may be applied to delinquent accounts. Delinquent accounts may be placed with an outside collection agency or pursued through small claims court. You will be responsible for court costs, attorney fees, and/or collection agency fees.

RECEPTION AREA. Seating in our reception area is limited. Please try to limit the number of people who accompany you to your appointment. It may be inappropriate to have small children in the examination room with you. Please do not leave children unattended in the waiting room. **Phone calls, food and/or drinks are not allowed in the waiting area.**

TELEPHONE CALLS. In order to be fair to our scheduled patients, every effort is made not to interrupt the provider/s during patient visits. Patient calls and messages are triaged by staff, and a member of our support staff may return responses to you.

PRESCRIPTION REFILLS. Please bring your medicine bottles at each office visit. This will allow us to reconcile medications, as well as check for medications that may be running out. We will gladly refill these medications at the same visit. For prescription refills, please call your pharmacy first as you may have refills remaining and request them to e-request or fax for fastest service. **Please allow <u>two business days</u> for completion of your prescription refill requests that is outside your visit date. To avoid running out of your medications request your prescriptions well in advance of weekends and holidays. We will only provide medication for 30 days maximum if you have not had a visit within the previous 6 months.**

NOTICE OF PRIVACY PRACTICES. I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

CONTROLLED SUBSTANCE, NARCOTICS, PSYCHOTROPIC MEDICINES – *<u>Before</u>* a new patient with a history of controlled substance prescription use receives the first prescription from us : 1.) patient must provide medical records documenting previous medical work-up regarding the complaint necessitating these prescriptions and notes from previous physicians that prescribed these medications; 2.) must agree to urine comprehensive drug screen 3.) our office will search on California's Prescription Drug Monitoring Program database, (CURES - Controlled Substance Utilization Review and Evaluation System) the patient's pattern of prescription drug use and, if long-term use is anticipated, 4.) execute a completed controlled substance contract.

APPOINTMENT CANCELLATION. We are committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (714) 462-8383 at least 24 hours prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** You may be discharged from our services if 3 cancellations occur in a row and/or 2 no-show appointments.

I understand that I will be charged a **$50 cancellation fee** for appointments I fail to cancel within 24 hours.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original.

_____ _____ _____

Patient (or Guardian)Name | Patient (or Guardian) Signature | Date

[ ] I would like to receive a copy of this document.

[ ] I would like to receive a copy of the Notice of Privacy Practices.

Patients Name: _____

Past Medical History	Time / Year Diagnosed	Time / Year Diagnosed	Time / Year Diagnosed
	[] Hypertension _____	[] Skin disorders _____	[] Autoimmune Ds _____
	[] High cholesterol _____	_____	_____
	[] Heart Attack _____		[] Cancer
	[] Heart Failure _____	[] Thyroid disorder	_____ _____
	[] Diabetes _____	[] Hypothyroidism _____	_____ _____
	[] GERD/Heartburn _____	[] Hyperthyroidism _____	
	[] Ulcer _____		[] Breast disorders _____
	[] Asthma _____	----------	_____
	[] COPD _____		[] GYN disorders _____
	[] Stroke _____	[] Alcoholism _____	_____
	[] Seizure _____	[] Depression _____	
	[] Headache _____	[] Anxiety _____	[] Serious Accident _____
	[] Insomnia _____	[] Mental Illness _____	_____
	[] Sleep Apnea _____	_____	[] Previous hospitalizations
	[] Arthritis _____	[] Drug Dependency _____	_____ _____
	[] Anemia _____	_____	_____ _____
	[] Blood Clots _____		_____ _____
	[] Blood Disorders _____		

Surgical History	Time / Year Diagnosed	Time / Year Diagnosed	Time / Year Diagnosed
	[] Heart _____	[] Breast _____	[] Orthopedic _____
	[] Pacemaker _____	[] Uterus _____	[] Hip _____
	[] Stent/s _____	[] Ovary _____	[] Knee _____
	[] Abdominal _____	[] Prostate _____	[] Back _____
	[] Appendix _____	[] Cataract _____	[] Others _____
	[] Gallbladder _____		[] Others _____

Medications			
Name	Dose (mg)	Dosage (how many times per day)	Diagnosis/es
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
Supplements and Over The Counter Medications			
Name	Dose (mg)	Dosage (how many times per day)	Diagnosis/es
1.			
2.			
3.			

Medication and Food Allergies					
Medication Allergies: [] None			**Food Allergies:** [] None		
Name	Reaction	Date	Name	Reaction	Date

Patients Name: _____

Family Medical History																				
	Alive and well	Cause of death or major illness	Heart Attack	Heart Disease	High cholesterol	Stroke	Diabetes							Breast Cancer	Colon Cancer	Prostate Cancer	Lung Cancer	Skin Cancer	Other Cancer (type)
Father																			
Mother																			
Brothers																			
Sisters																			
Aunts																			
Uncles																			
Paternal Grandfather																			
Paternal Grandmother																			
Maternal Grandfather																			
Maternal Grandmother																			

Social History				
Occupation		**Education**	[] Grade school [] High School [] College [] Post graduate [] _____	
Marital Status	[] Single [] Married [] Widowed [] Divorced [] Separated # of children: _____			
Sexual Activity	Current sex partner(s): [] Male [] Female	Sexually active: [] Yes [] No [] Not currently	Birth Control method: [] none needed name: _____	
Drink caffeine	[] Never	[] Yes, cups per day ____		
Alcohol	[] Never	[] Quit ____	[] Daily [] Heavy [] Occasional / Social # drinks/wk : ____	
Cigarette Smoking	[] Never	[] Quit year: _____ # of packs/day ___ # of years ___	[] Current smoker: packs/day ___ # of years ___ Are you interested in quitting? [] Yes [] No Other Tobacco: [] pipe [] cigar [] snuff [] chew	
Recreational Drugs	[] Never	[]Daily	[] Occasional Type/s: _____ Have you ever used needles to inject drugs? [] Yes [] No	

Health Maintenance					
Preventive Tests	Year done	Result		Year done	Result
PAP smear (female 21-65)	_____	_____	Colonoscopy (50-75)	_____	_____
Chlamydia (sexually active, 24)	_____	_____	Mammogram (50-74)	_____	_____
Hep C screening (1945-65)	_____	_____	Bone Density Scan (65+)	_____	_____

Immunizations					
Meningococcal (>1dose)	_____	Varicella/Chickenpox (2 doses)	_____	Influenza (yearly)	_____
HPV (3 doses)	_____	MMR (2 doses)	_____	Shingles/Zoster (>60)	_____
Hepatitis A (2/3doses)	_____	Tetanus (Tdap >7y.)	_____	Pneumonia (Prevnar13)	_____
Hepatitis B (3 doses)	_____	Tetanus (Td booster)	_____	Pneumonia (Pneumovax23)	_____

Advance Directive	**[]** Yes [] No Do you have an advanced directive? http://www.caringinfo.org/files/public/ad/California.pdf
Adult TB Risk Assessment	**[]** Yes [] No History of positive TB test or TB disease **[]** Yes [] No One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue). **[]** Yes [] No Close contact with someone with infectious TB disease. **[]** Yes [] No Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter. **[]** Yes [] No Foreign born person* **[]** Yes [] No Traveler to high TB-prevalence country for more than 1 month * *Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.