JiKi Medical Associates, LLC
JiYon Hwang-Ki, M.D.*
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PATIENT REGISTRATION

DATE:_____
PATIENT NAME: _____ DATE OF BIRTH:_____
SOCIAL SECURITY NO:_____ SEX:_____
ADDRESS: _____ _____
_____
(CITY) (STATE) (ZIP CODE)
HOME #: (___)_____ __CELL #: ( )_____WORK #:(___)_____
MARITAL STATUS: (SINGLE) (MARRIED) (DIVORCED) (WIDOWED)
PURPOSE OF VISIT
_____
_____

ALLEGIES TO MEDICATION_____

MEDICAL INSURANCE INFORMATION
PRIMARY INSURANCE:
NAME OF COMP: _____ POLICY NO:_____
NAME OF POLICY HOLDER: _____ DATE OF BIRTH:_____
SECONDARY INSURANCE:
NAME OF COMP: _____ POLICY NO:_____
NAME OF POLICY HOLDER: _____ DATE OF BIRTH:_____

PERSON TO NOTIFY IN CASE OF EMERGENCY
Name: _____ Relationship: _____
Phone: Home _____ Cell _____
PERSON TO NOTIFY WHEN WE CANNOT REACH YOU
Name: _____ Relationship: _____
Phone: Home _____ Cell _____

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH_____ AND ASSIGN DIRECTLY TO DR. JI YON HWANG-KI ALL MEDICAL BENEFITS. IF ANY, OTHER WISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE:_____ DATE:_____

Notice of Privacy practices
Patient Acknowledgement

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes, treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested , restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of Its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of privacy practices on request.

Signature:_____ Date:_____

Relationship to patient (If signed by a personal representative of patient):_____

PATIENT HEALTH HISTORY QUESTIONNAIRE

NAME: _____ SEX: M / F DOB:

Marital status: Single/Partnered/Married /Separated/Divorced/Widowed

Previous or referring doctor: _____

Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness: Measles / Mumps / Rubella / Chickenpox / Rheumatic Fever / Polio / other

Immunizations and dates:
Tetanus - _____Pneumonia
Hepatitis -_____ Chickenpox
Influenza -_____MMR Measles,Mumps,Rubella
List any medical problems that other doctors have diagnosed:

Surgeries (Year/Reason):
Other hospitalizations (Year/Reason):
Have you ever had a blood transfusion? Yes or no When?
List your drugs

Allergies to medication
Do you drink alcohol?
Do you use tobacco? _____#of years____or year quit

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	**Chest/Heart**	**Head/Neck**	**Back**	**Ears**
Intestinal	**Nose**	**Bladder**	**Throat**	**Bowel**
Lungs	**Sleep**	**Weigh**	**Other**	

Are you sexually active? _____If not trying for a pregnancy list contraceptive or barrier method used:
Any discomfort with intercourse?
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?
Do you live alone? Yes or No
Do you have frequent falls? Yes or No When?
Do you have vision or hearing loss?
Do you have an Advance Directive and/or Living Will?
Would you like information on the preparation of these?
Do you cry frequently? Yes or No _____Have you ever attempted suicide? Yes or No. When?

FAMILY HEALTH HISTORY

	Age	Significant Health Problems
Father		
Mother		

Sibling	Age	Sex	Significant Health Problems

Children	Age	Sex	Significant Health Problems

Have you ever done Colonoscopy, when?
Was it normal or abnormal?
When is your next exam for Colonoscopy?Unknown / 1yr / 3yr / 5yr / 10yr.
Have you ever done EGD, when?
Was it normal or abnormal?
When is your next exam for EGD? Unknown / 1yr / 3yr / 5yr / 10yr.
Have you had Hepatitis B test positive? Yes / No. what was it?
Have you had PPD(tubeculine) test positive? Yes / No When?

WOMEN ONLY.

Age at onset of menstruation:
Date of last menstruation:
Period every 3 week/ 4 week / 5 week
Heavy periods, irregularity, spotting, pain, or discharge? Yes / No
Number of pregnancies _____Number of live births
Any abortion? _____ Are you pregnant or breastfeeding? Yes / No.
Have you had a D&C, hysterectomy, or Cesarean? Yes / No.
Any urinary tract, bladder, kidney infections within the last year? Yes / No
Any blood in your urine? Yes / No.
Any problems with control of urination? Yes / No.
Any hot flashes or sweating at night? Yes / No.
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes / No.
Experienced any recent breast tenderness, lumps, or nipple discharge? Yes / No.
Date of last pap and rectal exam? _____ Normal/ abnormal?

MEN ONLY.

Do you usually get up to urinate during the night? Yes / No.
If yes, # of times
Do you feel pain or burning with urination? Yes / No.
Any blood in your urine? Yes / No.
Do you feel burning discharge from penis? Yes / No.
Has the force of your urination decreased? Yes / No.
Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes / No.
Do you have any problems emptying your bladder completely? Yes / No.
Any difficulty with erection or ejaculation? Yes / No.
Any testicle pain or swelling? Yes / No.
Date of last prostate and rectal exam?