Brighton Family Medicine

PATIENT INFORMATION

Patient Name: Last:_____ First:_____ Mid Initial:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip:_____ Cell Phone:_____

Date of Birth:_____ Social Security#:_____ Work Phone:_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Patient's Employer:_____ Occupation:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact:_____ ph#:_____ Relationship: _____

Referred by:_____ Email address:_____

Spouse's Name:_____ Phone number:_____

PRIMARY CARD HOLDER'S INFORMATION– Primary Insurance

Insured Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Social Security#:_____

Employer:_____ Wk. Phone:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Primary Insurance:_____ Phone:_____

Group#:_____ Policy#:_____

INSURANCE COMPANY INFORMATION – Secondary Insurance

Insured Name:_____

Address**:**_____ City**:**_____ State**:**_____ Zip**:**_____

Date of Birth:_____ Social Security#:_____ Phone:_____

Secondary Insurance:_____ Phone:_____

Group#:_____ Policy#:_____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to S and S Kim Group PC dba Brighton Family Medicine. We will gladly file your insurance claim, however, payment for copays and deductibles are required at the time services are rendered. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to S and S Kim Group PC dba Brighton Family Medicine. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

SIGNATURE:_____ Date:_____

1720 W. Horizon Ridge Pkwy, Ste. 140 Henderson, NV 89012

Tel: 702.566.5445 Fax: 702.566.5035

Brighton Family Medicine

Medical History

Place a circle around the "Yes" or "No" to indicate if you have had any of the following:								
AIDS/HIV	yes	no	Epilepsy	yes	no	Rash	yes	no
Allergies to anesthesia	yes	no	Eye problems	yes	no	Respiratory disease	yes	no
Allergies to medicines or drugs	yes	no	Fainting	yes	no	Rheumatic fever	yes	no
Anemia	yes	no	Foot or leg cramps	yes	no	Shortness of breath	yes	no
Angina	yes	no	Gout	yes	no	Sinus problems	yes	no
Arthritis	yes	no	Headaches	yes	no	Special diet	yes	no
Artificial heart valve or joints	yes	no	Heart disease	yes	no	Stroke	yes	no
Asthma	yes	no	Hemophilia	yes	no	Swelling in ankles or feet	yes	no
Back problems	yes	no	Hepatitis or jaundice	yes	no	Swollen neck glands	yes	no
Bleeding disorders	yes	no	High blood pressure	yes	no	Tired feet	yes	no
Cancer	yes	no	Kidney problems	yes	no	Thyroid	yes	no
Chemical/ alcohol dependency	yes	no	Liver disease	yes	no	Tuberculosis	yes	no
Chest pain	yes	no	Low blood pressure	yes	no	Ulcers	yes	no
Chronic diarrhea	yes	no	Neuropathy	yes	no	Varicose veins	yes	no
Circulatory problems	yes	no	Phlebitis	yes	no	Venereal disease	yes	no
Diabetes	yes	no	Psychiatric care	yes	no	Weight loss, unexplained	yes	no
Ear problems	yes	no	Radiation treatment	yes	no	Other problems	yes	no

What surgeries you have had: (use back of sheet if necessary)

Medications you take including over the counter: (use back of sheet if necessary)

Name	Dose	Frequency

Pharmacy Name & Location:

Allergies:

Are you now or have you been under any other doctor's care for any reason over the past two years? Yes No

Name of Doctor or Practice	Location	Telephone # if available

Name: **Birthdate:** **Date:**

Brighton Family Medicine

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my health care, S and S Kim Group PC dba Brighton Family Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that S and S Kim Group PC dba Brighton Family Medicine is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to S and S Kim Group PC dba Brighton Family Medicine to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

X_____ _____
Patient/Legal Guardian Signature Date

1720 W. Horizon Ridge Pkwy, Ste. 140 Henderson, NV 89012
Tel: 702.566.5445 Fax: 702.566.5035

Brighton Family Medicine

Date: _____/_____/_____

Re: Request of Medical Information

Patient Name: _____

DOB: _____ Social Security # _____

I hereby request that you release:

_____

_____

_____

To:

Brighton Family Medicine
S. Steven. Kim M.D.
1720 W Horizon Ridge Pkwy Ste 140
Henderson NV 89012
T: (702) 566-5445 F: (702) 566-5035

X_____Date: _____
Patient/Legal Guardian Signature