PATIENT INFORMATION

DATE: ____________

PATIENT'S NAME ____
LAST FIRST MID

PATIENT'S DOB ______________ SS# ______________ SEX: M / F

PATIENT'S ADDRESS ____________________ PHONE (H) ____________
(W) ____________
____________________ (C) ____________
(CITY, STATE, ZIP)

STATUS: SINGLE: ____ MARRIED: ____ DIVORCED: ____ SEPARATED: ____

PATIENT'S EMPLOYER: NAME: ______________________________________

ADDRESS: ____
STREET CITY STATE ZIP

PHONE: ____________________ EXT: ________ HOW LONG EMPLOYED ________

PATIENT'S SPOUSE

NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____________________ PHONE (H) ____________
(IF DIFFERENT)
(W) ____________
____________________ (C) ____________

SPOUSE'S EMPLOYER: NAME: ______________________________________

ADDRESS: ____
STREET CITY STATE ZIP

PHONE: ____________________ EXT: ________ HOW LONG EMPLOYED ________

INSURANCE INFORMATION

INSURANCE COMPANY: ____

GROUP #: ______________ SUSCRIBER ID #: ______________

PRIMARY POLICY HOLDER: ____

RELAION TO PATIENT: ______________ SS# ____________ DOB ____________

ADDRESS (IF DIFFERENT FROM PATIENT / SPOUSE) ____________________

PHONE (IF DIFERENT) (H) ____________ (W) ____________ (C) ____________

*** IS PATIENT COVEREDBY ANY OTHER INSURANCE?*** YES ___ NO ___

INSURANCE COMPANY: ____

GROUP #: ______________ SUSCRIBER ID #: ______________

PRIMARY POLICY HOLDER: ____

RELAION TO PATIENT: ______________ SS# ____________ DOB ____________

ADDRESS (IF DIFFERENT FROM PATIENT / SPOUSE) ____________________

PHONE (IF DIFERENT) (H) ____________ (W) ____________ (C) ____________

EMERGENCY CONTACT: NAME: ______________________________________

RELATION: ______________ PHONE: ______________

L. KIN SZETO, M.D.
JEREMY W. SZETO, D.O.

Dr J Szeto

ALLERGIES: YES: ______ NO: ______

MEDICATIONS ALLERGIC TO:	REACTION

CURRENT MEDICATION	DOSE	FREQUENCY	REASON

INDICATE IF YOU HAVE ANY OF THE FOLLOWING WITH DATE OF DIAGNOSIS OR ONSET

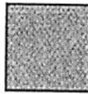
ILLNESS	DATE (MM/YR)	ILLNESS	DATE (MM/YR)
ANEMIA		HIGH CHOLESTEROL	
ARTHRITIS		HIGH BLOOD PRESSURE	
ASTHMA		MIGRAINE HEADACHES	
CANCER (TYPE:)		MONONEUCLEOSIS	
DEPRESSION		PNEUMONIA	
DIABETES		SEXUALLY TRANS INFECTIONS	
EMPHYSEMA		STOMACH ULCERS	
GALLBLADDER/GALLSTONES		STROKE	
GOUT		THYROID DISEASE	
GLAUCOMA		TUBERCULOSIS	
HEART DISEASE (HEART ATTACK)		*other:*	
HEPATITIS (TYPE:)			

SURGERY / OPERATIONS:	DATE

SOCIAL HABITS
ALCOHOL (circle) YES / NO Drinks per week:
TOBACCO YES / NO Packs per day:
ILLEGAL/RECREATIONAL DRUGS YES / NO
[list agent(s)]:

FAMILY HISTORY

Has any of the family or close relatives had the following listed below:

If UNKNOWN / ADOPTED check this box: 

CONDITION	YES	NO	(if yes, whom [mom, dad, sibling, aunt/uncle])
ARTHRITIS			
CANCER breast			
colon			
prostate			
skin			
thyroid			
pancreatic			
stomach			
throat/esophageal			
[other cancer]:			
CHEMICAL/DRUG DEPENDENCY			
DIABETES			
HEART ATTACK			
HIGH BLOOD PRESSURE			
MENTAL DISORDER			
STROKE			
OTHER NOT LISTED:			

HIPAA Consent Form

I understand that as a part of healthcare services, Jeremy W. Szeto creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protect Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

____

Patient's Signature

DR J SZETO

Coordination of Benefits for Other Insurance Coverage

If you are considered a spouse and/or dependent on another policy, we will need your other insurance information. By coordinating benefits among all insurance carriers, the insured receives the maximum benefits available.

* indicates required fields, as applicable

PATIENT » *Name of Patient: ______________________ *Date of Birth: ______________

INSURED » *Name of Insured: ______________________ *Phone #: ______________

*Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other ______________

Group or Claim #: ______________ Subscriber / Member #: ______________

***Does the Patient have other insurance coverage?**

☐ YES » Continue with form ☐ NO » Go to **Signature** section

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OTHER INSURANCE CARRIER:

* Name of the Subscriber for the Other Insurance policy: ______________
* Name of the Employer: ______________
* Name of Other Insurance Carrier: ______________

Insurance Carrier Claim address: ______________

Insurance Carrier phone number: ______________

*Policy Number: ______________ *Group Number: ______________

*Beginning date of Coverage: ______________ *End date of Coverage (if applicable): ______________

Other insurance covers? ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name of Dependent(s): ______________

Relationship of other insurance member to child: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other______

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other______

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other______

Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes ☐ No

Relationship of party with decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other______

Name of responsible party: ______________

Address: ______________

Name and date of birth of both parents	Mother's name: Date of Birth:	Father's name: Date of birth:

SIGNATURE:

*Insured or Patient Name (print): ______________

*Signature of Insured or Patient: ______________ *Date: ______________