KALLAL MEDICAL GROUP

Patient Registration Record

PATIENT INFORMATION:

PATIENT NAME | AGE | SEX | DATE OF BIRTH

ADDRESS | APT # | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | E-MAIL (☐ GMAIL ☐ HOTMAIL ☐ YAHOO)

☐ Single ☐ Married ☐ Divorced
☐ Legally Separated ☐ Widowed

MARITAL STATUS | SOCIAL SECURITY NUMBER | RELIGION | LANGUAGE

RACE	ETHNICITY
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Other Pacific Islander ☐ White ☐ Other	☐ Hispanic or Latino ☐ Not Hispanic or Latino

PATIENT EMPLOYER INFORMATION: ☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED - DATE:_____

EMPLOYER NAME | PHONE | OCCUPATION

ADDRESS | CITY | STATE | ZIP CODE

GUARANTOR INFORMATION: ☐ SAME AS PATIENT ☐ OTHER – PATIENT'S RELATIONSHIP: _____

GUARANTOR NAME | GUARANTOR SSN | GUARANTOR DOB

ADDRESS | CITY | STATE | ZIP CODE

GUARANTOR EMPLOYER NAME | PHONE (☐ home ☐ cell ☐ work) | OCCUPATION

ADDRESS | CITY | STATE | ZIP CODE

EMERGENCY CONTACTS:

NAME | PHONE | RELATIONSHIP

NAME | PHONE | RELATIONSHIP

PRIMARY INSURANCE: ☐ SAME AS PATIENT ☐ SAME AS GUARANTOR ☐ OTHER

NAME OF INSURANCE CARRIER | POLICY NUMBER | GROUP | PHONE

ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER NAME | SUBSCRIBER SSN | SUBSCRIBER DOB

SECONDARY INSURANCE: ☐ SAME AS PATIENT ☐ SAME AS GUARANTOR ☐ OTHER

NAME OF INSURANCE CARRIER | POLICY NUMBER | GROUP | PHONE

ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER NAME | SUBSCRIBER SSN | SUBSCRIBER DOB

REFERRAL:

How did you hear about us? _____

KALLAL MEDICAL GROUP

PAST MEDICAL HISTORY

Name: _____ Date: _____

If checked, please indicate year of diagnosis:

☐ Diabetes	_____	☐ Asthma	_____	☐ Sinusitis	_____
☐ Coronary Disease	_____	☐ Kidney Disease	_____	☐ Allergies	_____
☐ High Blood Pressure	_____	☐ Colon Cancer	_____	☐ Thyroid Disease	_____
☐ Stroke	_____	☐ Breast Cancer	_____	☐ Migraine	_____
☐ High Cholesterol	_____	☐ Acid Reflux	_____	☐ Glaucoma	_____
☐ Lung Disease	_____	☐ Hiatal Hernia	_____	☐ Depression	_____

Surgical History

☐ Gall Bladder	_____
☐ Hysterectomy	_____
☐ C-Section	_____
☐ Heart Surgery	_____
☐ Cancer Surgery	_____
☐ Appendix	_____
☐ Tonsillectomy	_____

Immunizations

☐ Tetanus	_____
☐ Pneumovax	_____
☐ Hep B	_____
☐ Hep A	_____
☐ Influenza	_____
☐ Other	_____

_____

Major Injuries

Type	Date

Social History

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Alcohol: Number per _____ Day _____ Week _____ Month

Tobacco: ○ None ○ Past ○ Current Type _____ Amount _____ Years _____

Street Drugs: _____ _____ _____ _____

Seat Belt: ○ Always ○ Seldom ○ Never

Occupation

Occupation Risks: ☐ Noise ☐ Fumes ☐ Back Strain

KALLAL MEDICAL GROUP

FAMILY HISTORY

If checked, please list relationship:

☐ High Blood Pressure	_____	☐ Diabetes	_____	☐ Drug Abuse	_____
☐ Stroke	_____	☐ Colon Cancer	_____	☐ Domestic Violence	_____
☐ Heart Attack	_____	☐ Breast Cancer	_____	☐ Child Abuse	_____
☐ High Cholesterol	_____	☐ Other Cancer	_____	☐ Hereditary Disorders	_____
☐ Coronary Disease	_____	☐ Alcoholism	_____	☐ Mental Illness	_____

	Age	Current Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

ARE YOU ALLERGIC TO ANY MEDICATIONS? ◯ Yes ◯ No

(If yes, please list medications)

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ◯ Yes ◯ No

(If yes, please list medications, including herbal)

_____

_____

_____

_____

_____

*If you need additional space to list medications, please attach a seperate sheet.

KALLAL MEDICAL GROUP

Patients Protected Health Information Preferences

Please refer to the "HIPAA NOTICE OF PRIVACY PRACTICES" trifold provided for more information about your Protected Health Information.

Telephone Communication Preferences

Location	May we call you here?		Can we leave a message?	
• Home	□ Yes	□ No	□ Yes	□ No
• Work	□ Yes	□ No	□ Yes	□ No
• Mobile Phone	□ Yes	□ No	□ Yes	□ No

Email Communication Preferences

May we communicate with you via email? □ Yes □ No

If yes, please provide your email address:

Patient Portal Activation

May we activate you on our secure patient portal? □ Yes □ No

If you wish to activate access to the patient portal, then you must accept email communication and provide an email address above

Mail Communication Preference

May we send mail to your home address? □ Yes □ No

If no, please provide an alternate mailing address below:

Address _____ City _____ State _____ Zip _____

Other Communication - Other than you, your insurance carrier, and health care providers involved in your care, who can we talk with about your health care information?

Check all that apply	Name	Phone Number			
□ Spouse	_____	_____	□ Home	□ Work	□ Cell
□ Child	_____	_____	□ Home	□ Work	□ Cell
□ Parent	_____	_____	□ Home	□ Work	□ Cell
□ Other	_____	_____	□ Home	□ Work	□ Cell

□ By checking this box, I do not wish to disclose any information with anyone

- I acknowledge that I have received the "HIPAA Notice of Privacy Practices"
- I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information
- I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information
- I acknowledge should I change my mind I have the right to revoke all active authorizations on file by completing a Revocation of Authorization to Release Protected Health Information

_____ _____ _____

Patient / Representative Signature Date Time

_____ _____

Printed Name Relationship to Patient

KALLAL MEDICAL GROUP

Consent for Care

I, with my signature, authorize Kallal Medical Group, and any employee working under the direction of the physician to provide medical care for me, or to this patient for which I am legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling assessment or review of physical or mental status/function of the body.

I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. However, I understand that doing so may hinder my treatment and/or medical outcome.

This consent includes contact and discussion with other health care professionals for care and treatment.

Personal Valuables Authorization

I have been informed and understand that the facility **WILL NOT ASSUME RESPONSIBILITY** for any personal property I may bring and/or keep in the facility during my stay.

Privacy Notice Acknowledgement

I have received a copy of the Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act.

I acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, which tells me how to register any complaint I might have.

I understand that if I have questions or complaints, I may contact the Privacy Officer at 1-817-431-0606 or via email at manager@kallalmedicalgroup.com.

I understand that if I allow anyone to accompany me throughout my visit while I receive treatment and my personal health information is discussed, this will constitute an implied consent regarding the disclosure of my personal health information in the presence of the individual.

Accidental Exposure of Healthcare Worker

I understand and acknowledge that if any person is exposed to my blood or other bodily fluid, the facility may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

The undersigned certifies that she/he is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____ _____

Printed Name Date

_____ _____

Patient/Personal Representative Signature Relationship to Patient

KALLAL MEDICAL GROUP

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and pre-authorizations requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayments or deductibles, coinsurance amounts and any balance deemed not to be a covered benefit of the insurance policy. These amounts will be due at time of service.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- We will ask to make a copy of your ID and insurance card for our records at each appointment. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance.
- If your insurance company denies payment because of benefit limitations or non-covered services, you will be responsible for the charges.
- There is a $35 fee for all returned checks.
- If you do not show up for an appointment or cancel with less than 24 hours' notice, you will be charged $25. You must pay this fee before you can schedule a new appointment. Patients with 3 missed appointments may be terminated from Kallal Medical Group.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment of services provided to me, I assume financial responsibility and will pay for all such charges in full.

_____ _____

Printed Name Date

_____ _____

Patient/Personal Representative Signature Relationship to Patient

KALLAL MEDICAL GROUP

Allergy History Questionnaire

Patient Name: _____ DOB: _____

Contact Number: _____ Date: _____

1. During which months do symptoms most often occur?

☐ All Months

☐ January ☐ April ☐ July ☐ October

☐ February ☐ May ☐ August ☐ November

☐ March ☐ June ☐ September ☐ December

2. At what times and places are your symptoms **WORSE**?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

☐ At Home ☐ At Work/School ☐ Other Location: _____

3. Are your symptoms?

☐ Constant ☐ Erratic ☐ Rare

4. Do symptoms interfere with your activities?

☐ Not at all ☐ A little ☐ Moderately ☐ All the time

5. Family History:

☐ Asthma ☐ Eczema ☐ Sinus Problems ☐ Migraines

☐ Hay Fever ☐ Ulcers ☐ Nervous Disorder ☐ Colitis

Other: _____

Please Rate Your Symptoms 1 – 5 (#1 is low degree, 5 is high degree of symptom)

Eyes (itchy, watery or swelling):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Ears (itchy, draining or congested):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Nose (runny or congested):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Headaches (allergy related):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Cough (allergy related):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sneezing:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. Are you currently being treated for allergies? ☐ Yes ☐ No

_____ _____

Patient Signature Date