Dr. Curtis Kodama and Associates

PATIENT REGISTRATION FORM

Name _____ SS # _____

Street Address _____ Date of Birth _____ Gender: M F Marital Status: S M W D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Mobile _____ Email _____

Spouse's name _____

Spouse's employer / address _____

PATIENT EMPLOYER INFORMATION

Emloyer name _____ Tel. # _____

Employer street adress _____ City / State _____ Zip _____

Patient's occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel. # _____ Date of Birth: _____

Street adress _____ City / State _____ Zip _____

Relationship to patient _____

INSURANCE

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID# _____ Group # _____ Tel. # _____

Secondary Insurance Company Name _____

ID# _____ Group # _____ Tel. # _____

INFORMATION AND ASSIGNMENT OF BENEFITS

FAMILY MEMBERS

First Name	Last Name	Birthdate	Age	Sex

EMERGENCY CONTACT INFORMATION

Name of Person: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone No: _____

Work Phone No: _____

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical information necessary for care or treatment as well as to process this insurance claim.

Signature of responsible party: _____ Date: _____

PAYMENT OF BENEFITS ASSIGNMENT: I hereby authorize my insurance benefits to be paid directly to DR. CURTIS KODAMA AND ASSOCIATES, INC. I understand that I have full repsonsibility for all professional services rendered and will remit appropriate co-payment or charges at time of service.

Signature of responsible party: _____ Date: _____

TREATMENT OF MINOR: The undersigned parent or legal guardian of the above listed minor(s), do hereby authorize the physician of DR. CURTIS KODAMA AND ASSOCIATES, INC. and their staff to perform any x-ray examination, anesthetic, medical, or surgical operation or treatment, which is deemed advisable, in the office or hospital.

Signature of responsible party: _____ Date: _____

Dr. Curtis Kodama and Associates
865 Patriot Drive, Suit 103
Moorpark, CA 93021
(805) 532-2032 (805) 532-2844 fax

ELIGIBILITY GUARANTEE

I, _____ understand that I am eligible with
Name of Patient

_____ as of _____ through my
Name of Insurance **Month Day Year**

_____ employment at _____.
Own/Spouse's/Parent's **Name of Employer**

I have chosen Dr. Curtis Kodama and Associates, Inc. to be my medical group. I am aware that if the above is not true, I am (or the person responsible for me is) responsible for all charges related to the services provided to me and will pay, in full, all such charges within 30 days of receiving a bill from the medical group.

_____ _____
Signature of Patient / Responsible Party **Month/Day/Year**

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

For Office Use Only

Patient's Medical Record Number: _____

Witness's Initials (indicating receipt of form from patient) _____

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PATIENT CONSENT FORM

The Department of Health of Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entitites are most often required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objetions to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identifie as a national problem causing patients incovenience, aggravation, and money. We want you to know that all of your employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountablity Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromised our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Dr. Curtis Kodama and Associates, Inc.

DATE: _____

Dr. Curtis Kodama and Associates

PATIENT HISTORY FORM

NAME: BIRTHDATE: EMAIL:

IMMUNIZATIONS

	DATE
Influenza (Flu shot)	
Menactra (Meningitis shot)	
Prevnar13 (New pneumonia shot)	
Pneumovax (Old pneumonia shot)	
Tdap (Tetanus and whooping cough)	
Gardasil (HPV shot)	
Other	

TEST / EXAM

	RESULT	DATE
Pap Smear		
Mammogram		
Bone Density		
Colonoscopy		
Cholesterol		
Blood sugar/ HbA1C		
Eye Exam		
Tuberculosis screening		
PSA (Prostate labwork)		
Other		

CHRONIC MEDICAL PROBLEMS

ACUTE MEDICAL PROBLEMS

DRUG ALLERGIES

	TYPE OF REACTION

FOOD ALLERGIES

CURRENT MEDS

Medication	Dose	How often

SOCIAL HISTORY

Smoking Status:

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Less than 1 pack/day
- ☐ More than 1 pack/day

Coffee: Cups daily _____

Other caffeine _____

Alcohol: Drinks per week _____

Recreational Drugs: _____

Martial Status: S M W D SEP

Number of Children _____

Pregnancies ___ Abortions ___ Miscarries ___ Live Births ____

Occupation _____

SURGERIES

Reason	Date

FAMILY MEDICAL HISTORY

Father: _____

Mother: _____

Father's Parents: _____

Mother's Parents: _____

Siblings: _____

Children: _____