PATIENT INFORMATION FORM

DATE: ___/____/_____

환자 이름: _____ _____ _____ 생일: ___/___/___ 나이: ___ 성별: 남/여
LAST FIRST MI

집주소: _____ 시/주: _____ 우편번호: _____

E-MAIL: _____

집전화#: (____) _____-_____ 직장전화#:(____) _____-_____ 휴대전화# (____) ____-_____

법적 보호자나 대리인이 있으신 가요? YES /NO
만약 있으시다면 이름: _____ 관계: _____ 전화번호(____) ____-_____

비상시 연락 가능하신 분: _____ 관계: _____ 전화번호: (____) ____-_____

주치의: _____ 전화번호: _____

약국이름: _____ 위치: _____ 전화번호(____) ____-_____

가족이나 지인에게 당신의 의료기록을 공유하여도 되겠습니까?
_____ YES NAME(S) _____
_____ NO

청구 금액 책임자는 어느 분이십니까? _____ 관계? _____

주소: _____ 시/주소: _____ 우편번호: _____ 전화:(____) ____-_____

어떻게 저희 병원을 아셨나요?

SOCIAL HISTORY

미성년자 / 18 세 미만 입니까? ☐ 예 ☐ 아니오
"예" 인 경우 ☐부모와 동거 ☐부와 동거 ☐모와 동거 ☐법적 보호자와 동거_____

"아니오"인 경우
혼인관계: ☐미혼 ☐기혼 ☐동거 ☐별거 ☐이혼 ☐사별

음주여부: ☐전혀 음주한 적 없음 ☐금주 ☐알코올중독 이력
☐현재 음주 - TYPE _____☐가끔 ☐때때로 ☐자주 ☐매일

흡연여부: ☐전혀 핀 적이 없음 ☐금연 – 얼마나 오래 되었나요? _____
☐ 현재 흡연 - _____ PACKS/DAY FOR _____ YEARS

마약성 약물 사용여부: ☐전여 사용 안함
☐중단함 – 얼마나 오래되었나요? _____ 종류_____
☐ 현재 사용 중- 종류 _____☐가끔 ☐때때로 ☐자주 ☐매일

가족 내력 : ☐해당사항 없음
☐ 당뇨: TYPE 1 OR ☐ 당뇨: TYPE 2 ☐암 ☐심장질환
☐고혈압 ☐뇌졸증 ☐관상동맥 질환 ☐ 갑상선 질환
☐류마티스성 관절염
☐그외 질환 _____

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

환자 병력 : ☐해당사항 없음
현재 복용중인 약 이름, 용량, 복용방법을 자세히 기재해주십시오. (처방약, 일반 약 포함)
이름 용량 복용방법

_____
_____
_____
_____
_____
_____
_____

수술기록이 있으시다면 기재해주십시오: ☐해당사항 없음

수술종류	날짜	수술종류	날짜
_____		_____	
_____		_____	
_____		_____	

병원 입원기록 기재해주십시오: ☐해당사항 없음

입원 이유	날짜	입원 이유	날짜
_____		_____	
_____		_____	
_____		_____	

알레르기: ☐해당사항 없음
☐약물_____
☐마취 _____ ☐음식 _____
☐테이프 ☐고무 ☐갑각류 ☐요오드 ☐다른 종류_____

이중에 해당되는 질환이 있으셨습니까? : ☐해당사항 없음

위-식도 역류 성 질환	Y	N		섬유근통증후근	Y	N		신경장애	Y	N
빈혈	Y	N		통풍	Y	N		아물지않은 상처	Y	N
관절염	Y	N		심장마비	Y	N		폐렴	Y	N
천식	Y	N		심장질환	Y	N		소아마비	Y	N
허리통증	Y	N		간염	Y	N		류마티스 성 열	Y	N
방광염	Y	N		HIV+/AIDS	Y	N		겸상 적혈구 빈혈증	Y	N
비정상적인 출혈	Y	N		고혈압	Y	N		피부질환	Y	N
혈전	Y	N		신장 질환	Y	N		수면 성 무 호흡	Y	N
수혈	Y	N		간질환	Y	N		위궤양	Y	N
모세 기관지/폐기종	Y	N		저혈압	Y	N		뇌졸증	Y	N
암	Y	N		편두통	Y	N		갑상선 질환	Y	N
당뇨: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N		승모판 폐쇄 부전 증	Y	N		결핵	Y	N
치매/알츠하이머	Y	N		골다공증	Y	N		콜레스테롤	Y	N
다른 증상:										

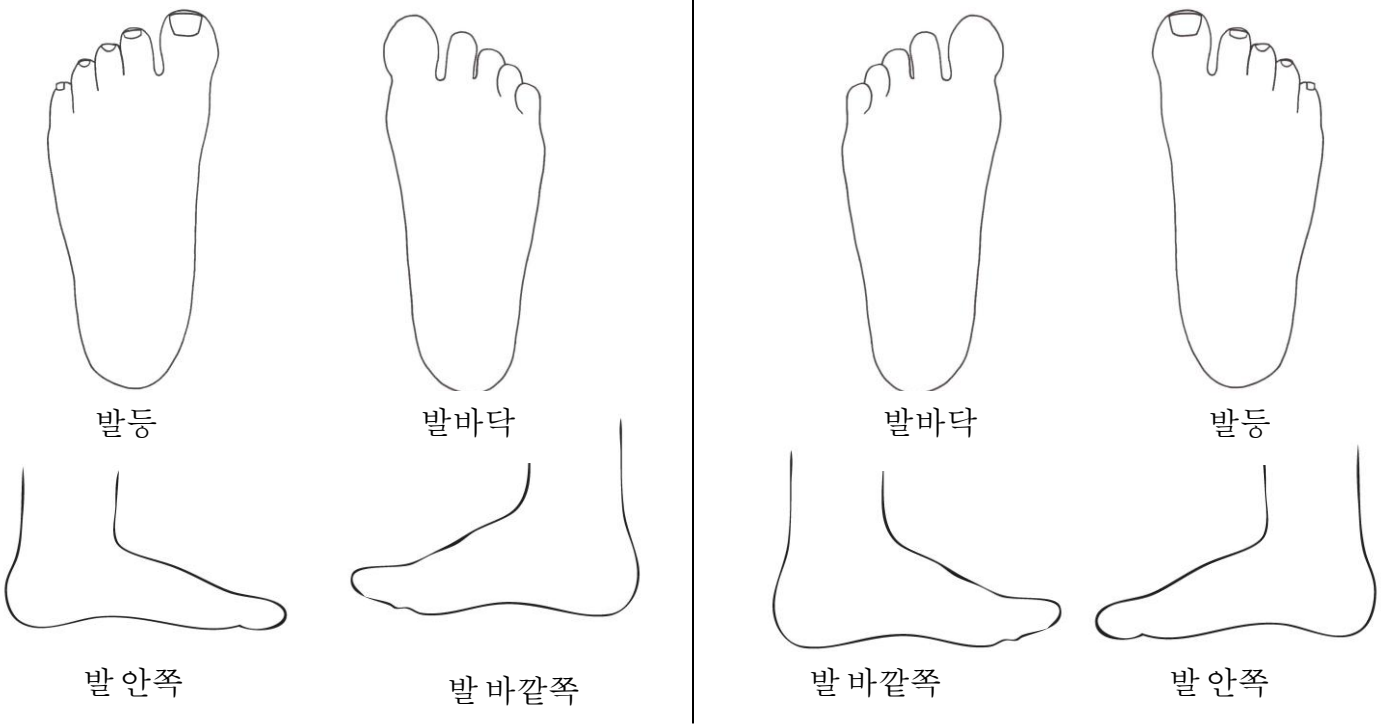
PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

현재 문제점

병원에 내원하신 이유는 무엇입니까?_____

아프거나 불편한곳은 어디인지 그림에 표기해주십시오.

왼발 **오른발**



첫 증상이 언제부터 시작되었습니까? _____ DAYS / WEEKS / MONTHS / YEARS

통증이나 증상:☐갑자기 시작됨 ☐점차적으로 진행됨

통증이 어떻게 느껴 지십니까? ☐통증 없음 ☐날카로움 ☐둔통 ☐쑤시거나 아림 ☐화끈거림
☐열감 ☐간지러움 ☐찔르는듯한 통증 ☐그외 _____

환자분의 통증강도가 0 에서 10 중 어느 정도에 해당되십니까?
(무통) 0 1 2 3 4 5 6 7 8 9 10 *(최고로 아픈 통증)*

첫 증상과 비교해서 현재는 어떠십니까? ☐똑같음 ☐점점 나빠짐 ☐좋아짐

어떤 상황이 통증이나 문제를 더 악화 시킵니까? ☐걷기 ☐서있을 때 ☐일상생활
☐휴식 ☐정장 구두 ☐하이힐 ☐평평한 신발 ☐앞이 막혀 있는 신발
☐뛸 때 ☐그외 _____

어떤 경우에 통증이나 불편함이 완화됩니까?_____

질환으로 인해 진료나 치료를 받으신 적이 있습니까?_____

MK Podiatry LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No._____

Address:_____

MK Podiatry LLC Name: _____

I have been given a copy of (MK Podiatry LLC)'s *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that (MK Podiatry LLC) has the right to change this *Notice* at any time. I may obtain a current copy by contacting the MK Podiatry LLC Privacy Official, or by visiting the (MK Podiatry LLC) web site at www.mkpodiatryllc.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For MK Podiatry LLC Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____

Signature of MK Podiatry LLC Representative Date

_____

Print Name

File original in patient's Business Office Record.

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.