Patient Registration

Patient Name_____Date of Birth_____

Address_____

City, State, Zip Code_____Phone #_____

SS#_____ Marital Status_____ Sex: ☐ M ☐ F

If Under 18-Name of Parent/Guardian_____Phone #_____

Parent/Guardian Address_____

City, State, Zip_____Phone #_____

Patient Employed at_____Work #_____

Address_____City, State, Zip Code_____
If Student – Are you a ☐ Full Time Student ☐ Part Time

In Case of Emergency, notify_____Phone #_____

Insurance Information

Name of Primary Insurance Carrier_____

Name of Subscriber (if other than patient)_____Relationship to pt._____

Subscriber Date of Birth_____Place of Employment_____

ID#_____Group#_____

Do you have a secondary insurance? ☐ Yes ☐ No

Name of Secondary Insurance Carrier_____

Name of Subscriber (if other than patient)_____Relationship to pt._____

Subscriber Date of Birth_____Place of Employment_____

ID#_____Group#_____

Patient History Form

Patient Name_____

Sex_____Age_____Date of Birth_____Home Phone #_____

Please answer all questions as best as you can. If you are uncertain about a question, your physician will help you. All information is kept confidential.

Past Medical Problems (asthma, diabetes, high blood pressure, cancer, epilepsy, etc.)

1_____6_____

2_____7_____

3_____8_____

4_____9_____

5_____10_____

Operations (tonsillectomy, appendix, gallbladder, hernia, hysterectomy, etc.) ☐ **None**

1_____Date_____4_____Date_____

2_____Date_____5_____Date_____

3_____Date_____6_____Date_____

Serious Injuries (automobile accidents, head injuries, fractures, burns, etc.) ☐ **None**

1_____Date_____4_____Date_____

2_____Date_____5_____Date_____

3_____Date_____6_____Date_____

Medications: List all medications you are currently taking including prescriptions, cold medications, aspirin, vitamins, and birth control pills. Please list all medication dosages and frequency taken.

☐ **None**

1_____ **5**_____

2_____ **6**_____

3_____ **7**_____

4_____ **8**_____

Allergies to Medications (list all medications you cannot take or have had a bad reaction to.) ☐ **None**

_____ **Reaction**_____

_____ **Reaction**_____

_____ **Reaction**_____

Health Habits

Yes	**No**	
☐	☐	**Do you drink alcohol? Amount?_____per ☐ day ☐ week ☐ month**
☐	☐	**Do you smoke? Amount?_____per ☐ day ☐ week ☐ month**
☐	☐	**Did you smoke in past? How much?_____ When did you quit?_____**
☐	☐	**Do you use caffeine? How much?_____**
☐	☐	**Have you used illegal drugs? List type_____**
☐	☐	**Do you exercise? How often?_____ What type?_____**
☐	☐	**Do you have any risk factors for AIDS of HIV infection?_____ (ex: I.V. drug use, multiple sex partners, unprotected intercourse, sex with gay/bisexual male)**

Health Maintenance

Last complete physicial **Date**_____
Cholesterol screening **Date**_____
Colonoscopy **Date**_____
Last prostate exam **Date**_____

Immunizations

Last tetanus shot_____ **Hepatitis B Series_____**
Last flu shot_____ **MMR_____**
Pneumonia Vaccine_____ **(measles, mumps, rubella vaccine)**

Gynecological History (women only)

Last Pap smear Date_____Number of pregnancies_____
Last Mammogram Date_____
Number of miscarriages_____Abortions?_____
Last menstrual period Date_____
Type of birth control used?_____
Number of children_____

Social History

Occupation ☐retired ☐student ☐unemployed ☐employed as_____
Living Situation ☐alone ☐with spouse/partner ☐with children other_____
Highest level of education_____Hobbies_____

Family Health History (blood relatives)
Mother's age now_____or at death_____
Father's age now_____or at death_____

Has any immediate family member (parents, brother, sister, grandparents, children) had:

Yes	No	
☐	☐	**Cancer_____**
☐	☐	**Heart Attack in close relative, if yes give age_____**
☐	☐	**Elevated Cholesterol_____**
☐	☐	**High Blood Pressure_____**
☐	☐	**Stroke_____**
☐	☐	**Diabetes_____**
☐	☐	**Asthma_____**
☐	☐	**Depression_____**
☐	☐	**Suicide_____**
☐	☐	**Alcoholism_____**
☐	☐	**Drug Problems_____**
☐	☐	**Sickle Cell anemia_____**
☐	☐	**Tuberculosis_____**
☐	☐	**Other illness/condition that runs in family_____**

FINANCIAL AND MISSED APPOINTMENT POLICY

Dr. Kevin D. Fujikawa thanks you for choosing this office for your primary care medical needs. Below is his financial policy:

We normally bill for your services to your insurance plan. If this is not approved in advance, your payment will be due at the time of service by check, cash, Visa or MasterCard.

You are responsible for any of the following as required by your plan: co-pay and coinsurance or deductible: all to be paid at the time of service.

You are responsible for any balance not covered by insurance (examples: denied services, or services not covered by your plan). We require timely payments in order to keep costs down for both of us as collection services are expensive for all involved.

A $25.00 service charge will be assessed for each non-sufficient fund check received back to our office. We understand that sometimes circumstances beyond your control may prevent you from keeping your appointment. Dr. Fujikawa will charge for repeated missed appointments at his discretion. There is a $25.00 charge for a missed appointment. There is a $50.00 charge for a missed complete physical appointment as these appointments typically book out 4 months or more. Kindly call at least 24 hours in advance to cancel a regular appointment or 48 hours to cancel a complete physical appointment.

We value your time and strive to see you as close to your appointment as possible. If you are going to be late to your appointment, please call the office to see if there will still be appropriate time for you to be seen. You may be asked to reschedule your appointment if there is not enough time.

Please sign below to indicate that you have read, understand, and agree with the above statements.

Patient/Parent_____Date_____

INSURANCE and/or MEDICARE PATIENT SIGNATURE AUTHORIZATION

I authorize any holder of medical and other information about me to be released to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, or billing agent of this physician or supply any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made to Kevin D. Fujikawa MD on any bills for services provided me by the physician.

I authorize that payment on my insurance claims be paid directly to Kevin D. Fujikawa MD. I understand that by signing below that I am responsible for the charges not covered by this assignment. Authorization is also given to release any and all medical information to the insurance company involved to allow to process any claims for my medical care.

Patient
Signature:_____Date_____

E-PRESCRIBING

Dr. Kevin D. Fujikawa has implemented ePrescribing in his office. ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe and secure way. This helps protect the privacy of your personal information. This way of prescribing also lets your doctor see important information – like drug interactions and your prescription history.

PATIENT CONSENT
I agree that Kevin D. Fujikawa MD may request and use my prescription medication history from other healthcare providers or third party pharmacy benefits payors for treatment purposes.

Patient Signature:_____Date:_____

Kevin D. Fujikawa, MD
FAMILY PRACTICE

4944 Sunrise Blvd Ste. H, Fair Oaks, CA 95628 | 916.966.8158

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____Birthdate_____

Signature_____Date_____

Kevin D. Fujikawa, MD
FAMILY PRACTICE

4944 Sunrise Blvd Ste. H, Fair Oaks, CA 95628 | 916.966.8158

Medical Information Release Form (HIPAA Release Form)

Name: _____
Date of Birth: _____/____/_____

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse_____ Phone:_____
☐ Child(ren)_____ Phone:_____
☐ Other_____Phone:_____

OR

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____
Date: ____/____/_____

Witness:_____
Date: ___/____/_____