## PATIENT INFORMATION 3200 Hillcrest Park Dr., Suite 200 Medford, OR 97504 541-773-6700

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. **Please fill in the blanks below the line**.

|  |
| --- |
| First Name MI Last Name Date of Birth Gender Age  |
| Parent’s Name (if Patient is a Minor) |
| Patient’s Social Security Number   |
| Home Address City State Zip |
| Mailing Address if Different City State Zip |
| Home Phone Number Cell Number Work Number E-Mail Address |
| Employer May we contact you at work? May we email you about promotions?   |
| Emergency Contact (name and phone number) Relationship |
| Primary Care Physician |
| FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES |
| Name Telephone |
| Address City State Zip |
| Primary Insurance Company Insurance ID No. Group ID No.   |
| Subscriber’s Name  |
| Secondary Insurance Company Insurance ID No. Group ID No.  |
| Subscriber’s Name  |
| Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Height: Weight: Date of Birth: Name:  |
| Chief Complaint for today: |
| ILLNESS/INJURY: Please check if you have ever had: |
| Yes | No |  | Yes | No |  |
|  |  | High blood pressure |  |  | Lung problems |
|  |  | Diabetes Type I or II |  |  | Bronchitis |
|  |  | Sleep Apnea |  |  | Emphysema |
|  |  | Heart disease/ Angina |  |  | COPD |
|  |  | Chest pain/tightness |  |  | Hay Fever |
|  |  | Heart Attack/ MI |  |  | Shortness of breath |
|  |  | History of heart murmur |  |  | Asthma |
|  |  | Congestive Heart Failure |  |  | Cancer |
|  |  | Pacemaker/ Defibrillator |  |  | Stomach Ulcers |
|  |  | Hepatitis |  |  | GERD / Heartburn |
|  |  | Liver Disease |  |  | Lymphedema |
|  |  | Stroke/ CVA |  |  | Kidney Disease/ Stones |
|  |  | Blood clots |  |  | Thyroid Disease |
|  |  | Blood Disorders  |  |  | Migraines |
|  |  | HIV/ AIDS |  |  | Arthritis |
|  |  | Anxiety |  |  | Rheumatoid Arthritis |
|  |  | Depression |  |  | Alcohol Abuse |
|  |  | Breast Cancer |  |  | Other:  |
| OPERATIONS: List names and dates of all operations you have had None |
| Year | Name of Operation | Type of Anesthetic, if Known Complications |
|  |  |  |
|  |  |  |
|  |  |  |
| Have you ever had a blood transfusion? Yes No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List any hospital admissions or medical conditions not list above:FEMALES ONLY: Are you pregnant? Yes No |
| MEDICATIONS: Please list all drugs you take and their dosages. None |
| Drug Dosage | Drug Dosage |
|  |  |
|  |  |
| ALLERGIES TO MEDICATIONS: Please list type and reaction None |
| Name of Drug Reaction | Name of Drug Reaction |
|  |  |
|  |  |
| Do you or have you ever taken narcotics? Yes No If yes, when/how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you or have you ever used nicotine products? Yes No If yes, when/how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you drink alcohol? Yes No If yes, how many drinks a week? \_\_\_\_\_\_\_ |
| FAMILY HISTORY: Has any member of your family ever had the following? |
| Which family member(s)? | Mother | Father | Sibling | Maternal Grandparent | Paternal Grandparent |
| Diabetes |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| Hypertension |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Mental Disease (anxiety, depression, etc) |  |  |  |  |  |
| Drug or alcohol addiction |  |  |  |  |  |
| Bleeding Disorders |  |  |  |  |  |
| Other: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Whom may we thank for referring you to our practice?

**CONSENT TO USE OR DISCLOSE**

**MEDICAL INFORMATION**

I authorize Brian R Kreul, MD, PC to use and disclose the health and medical information of

 for the purposes of Treatment, Payment and Health Care *(Name of patient)* Operations.\*

* **Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).
* **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization).
* **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Brian R Kreul, MD, PC’s ‘Notice of Privacy Practices’ for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here .

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in the lobby of our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Brian R Kreul, MD, PC has already used or disclosed the information in reliance on this CONSENT.

I hereby authorize Dr. Brian Kreul and staff to leave detailed, personal health and financial information by the following means:

* Home (number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cell (number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work (number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (or)

*Date Signature of patient*

*Date Signature of person authorized by law*

 **Confidential Patient Contact Person:**

*Based upon your written consent here-in the person specifically listed below is the only person to whom information will be released other than you, the patient.*

Name Relationship

Address

Telephone Date of Birth

***Welcome to our practice. We are pleased to participate in your health care, and it is our primary concern to provide you with the best possible care. The following is information concerning our financial policy. We will be happy to answer any of your questions professionally and confidentially.***

We will bill your primary and secondary insurance for you as a courtesy. Please read the following authorization for insurance billing.

**Release of Information/Financial Guarantee:**

I give my permission to Brian R Kreul, MD, PC to bill my insurance company whether the benefits are to come to me or to Brian R Kreul, MD, PC. It is my understanding that I am eligible for medical benefits through my insurance. However, in the event that my insurance company categorizes services rendered to me as ‘non-covered’’ or not medically necessary’, I agree to pay in full for all such charges. I fully understand that it is my responsibility to advise the Office Manager if my insurance requires pre-admission review, pre-admission authorization, or a second opinion, or if it contains any special provisions (to include exclusionary rider) which must be satisfied before payment by the insurance company can be made. If I fail to advise the Office Manager of such policy requirements and to comply in good faith, I agree to pay in full for all such charges.

**If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Doctor. (Co-pays will be made at the time of service.) I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplied by my Primary Care Doctor. For individuals with private insurance, the signature below authorizes direct assignment of benefits to the doctor.**

Patient (or Guardian) Signature

Date