Khin Khin Oo, M.D., Inc.

PATIENT REGISTRATION

Patient Personal Information

Name: ______________________________________

(As shown on insurance card)

Address: ______________________________________

City: ______________________________________

State: ______________________ Zip: _____________

Social Security Number: ______________________

Date of Birth: ___________ Gender: Female Male

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Email: ______________________________________

Occupation/Student: __________________________

Employer/School: ____________________________

Referred by: ________________________________

Responsible Party Information

Name: ______________________________________

Address: ______________________________________

City: ______________________________________

State: ______________________ Zip: _____________

Date of Birth: ________________________________

Social Security Number: _______________________

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Relationship to Patient: ________________________

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Insurance Information

Insurance Carrier: ____________________________

Insurance I.D. #: _____________________________

Type: HMO PPO POS Group#: ___________

Subscriber's Name: ___________________________

Subscriber's Date of Birth: ______________________

Emergency Contact

Name: ______________________________________

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Relationship to Patient: ________________________

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Spouse/Parent Information

(Complete only if spouse or parent is not the responsible party)

Name: ______________________________________

Address: ______________________________________

City: ______________________________________

State: ______________________ Zip: _____________

Date of Birth: ________________________________

Phone: Home Work Cell __________________

Phone: Home Work Cell __________________

Relationship to Patient: ________________________

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Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up labs, prescriptions, and other referrals from Khin Khin Oo, M.D Inc's office and to make and receive phone calls regarding my health and/or the billing related to the services provided by Khin Khin Oo, M.D..

Spouse: (Name) ______________________________

Caregiver: (Name) ____________________________

Children: (Name) _____________________________

Other: (Name) _______________________________

___________________________ ______________

SIGNATURE OF PATIENT OR REPRESENTATIVE TODAY'S DATE

"STAYING HEALTHY" ASSESSMENT Adults, 18 years of age and older				
Patient's Name (First, Last) ___________________________________	**Date of Birth** ________________	**Sex** Male Female	**Today's Date** ________________	**For Clinical Use** **Assistance needed:** Reading: Yes Interpreter: Yes

You and your healthcare team can work together towards better health.
Please answer these questions as best you can. You may check (/) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record. Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

Annual Review Date/Initials

		Yes	No	Skip	**Interventions Code/Date/Initials**
Sample Question and Answer:	Do you play sports?				
	Do You:				
1	Receive healthcare from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?				
2	See the dentist at least once a year?				
3	Drink milk or eat yogurt or cheese at least 3 times each day?				
4	Eat at least 5 servings of fruits or vegetables each day?				
5	Try to limit the amount of fried or fast foods that you eat?				
6	Exercise or do moderate physical activity such as walking or gardening 5 days a week?				
7	Think you need to lose or gain weight?				
8	Often feel sad, down or hopeless?				
9	Have friends or family members that smoke in your home?				
10	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?				
11	Smoke cigarettes or cigars or use any other kinds of tobacco?				
12	Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight?				
13	Often have more than 2 drinks containing alcohol in one day?				
14	Think you or your partner could be pregnant?				
15	Think you or your partner could have a sexually transmitted disease?				
	Have You:				
16	Or your partner(s) had sex without using birth control in the last year?				
17	Or your partner(s) had sex with other people in the past year?				
18	Or your partner(s) had sex without a condom in the past year?				
19	Ever been forced or pressured to have sex?				
20	Ever been hit, slapped, kicked, or physically hurt by someone?				
21	Do you have other questions or concerns about your health? (Please identify) ____ ____				

For Clinical Use
Intervention Codes: C:Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your healthcare provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form maybe transferred to state and local governmental and regulating agencies, contracted health plans, and healthcare providers.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications on that a communication of PHI is made by alternative means such as sending correspondence to the individual's office instead of the individual's house.

I wish to be contacted in the following manner:

☐ Home Telephone: ________________________________
- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone: ________________________________
- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Email: ____

☐ Other ____

☐ I hereby authorize Khin Khin Oo, M.D., Inc to release information as deemed necessary **without** prior consent.

____
PATIENT/GUARDIAN SIGNATURE

____
DATE

____
PRINT NAME

____
BIRTH DATE

The Privacy Rule generally request healthcare providers to take reasonable steps to limit the use or disclosure of, and requests by PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute and adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date	Disclosed to Whom Address or Fax #	Description of Item(s) Disclosed	Description/Purpose of Disclosure	By Whom Disclosed	Patient Notified