김진안 내과에 오신것을 환영합니다

JK INTERNAL MEDICINE & GERIATRICS P.C

*** 영문으로 기입하여 주십시오. ***

*** PLEASE WRITE IN ENGLISH ***

NEW PATIENT ONLY

[등록 날짜] /ENROLLED DATE			
환자성명 / PATIENT'S NAME **이름 FIRST NAME** **성 LAST NAME**	**생년월일 /** **DATE OF BIRTH**	**성별 /** **GENDER**	**소셜서큐리티 /** **SOCIAL SECURITY NUMBER**
	월 일 년 (MONTH) (DAY) (YEAR)	◉ M 남 ○ F 여	

주소 / ADDRESS / CITY / STATE / ZIP CODE	**전화번호 / PHONE NUMBER**
	가장 잘 되시는 번호를 적어 주세요. *Please write your primary contact number.* 집/Home ( ) 휴대폰/Cell phone( )
이메일 / E-mail _____@_____	

기타 연락처/ Other Contact Information	**비상연락처/ Emergency Contact**	**직업/Occupation**
전화번호/Phone Number 이름(관계) /Name (Relationship)	*In case of emergency, who to notify. 전화번호/Phone Number 이름(관계) /Name (Relationship)	Employer's Name Contact Information (if available)

기혼여부/MARITAL STATUS	**자녀 수/ Number of Children**	**보험/Insurance Information**
□ 결혼 Married □ 미혼 Single □ 미망인 Widowed □ 이혼 Divorced		Do You have Insurance? ❑ Yes ❑ No 보험회사명/Insurance Co. Name

Are you Hispanic or Latino? 히스패닉이나 라티노 이십니까? □ YES 예 □ NO 아니요

What language do you prefer to speak? 어떤 언어를 사용하십니까? _____

RACIAL CATEGORY

■ American Indian or Alaska Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White □ Other Race

Initial Patient History/ Questionnaire

Do you have or ever had any of the following diseases or conditions? (Diabetes, Hypertension, High Cholesterol, Arthritis, Cancer, CVA, Stroke, Hepatitis, Kidney Disease, Thyroid Disease, or Others)

*** 전에 질병을 앓으신 적이 있으십니까? Yes / No 있으시다면 어떤 것이 있습니까? (당뇨, 고혈압, 콜레스테롤, 관절염, 암, 심장질환, 뇌졸중, 뇌출혈, 간염, 신장질환, 갑상선 질환 또는 기타)**

_____

***Please list all your current medications (복용하시는 약을 작성해 주세요)**

_____

Please list any allergies to medications and list the reaction to the medications please (약물에 대한 알러지 반응)

_____

***Please list any surgery and approximate date (수술 및 입원 기록을 작성해 주세요)**

_____

Please list the Family History 직계가족 중 질병이 있으신 분이 계십니까? 있으시다면 작성해 주십시오

Father 부 _____

Mother 모 _____

Siblings 형제 자매 _____

Other Relatives 친척 _____

***Do you smoke? 담배를 피우십니까?◯Yes◯No**

If you do, How many? 만약 피우신다면 하루에 어느 정도 피우십니까? _____

***Do you drink alcohol? 술을 드십니까?◯Yes◯No**

If you do, please list the type and how much you drink per day 만약 드신다면 종류와 주량을 기입해 주시기 바랍니다_____

***Do you drink coffee? How much? 커피를 드십니까?◯Yes◯No**

만약 드신다면 하루에 몇 잔 드십니까?

_____

Do you work? 일을 하십니까?◯Yes◯No◯Retired If you

do, what is your job? 어떤 일을 하십니까? _____

의료비 재정동의서 및 의료보험 허가동의서 INSURANCE AGREEMENT

1. The undersigned certify that I (or my dependent) have insurance coverage with _____
(보험회사명 / insurance co. name)
assign directly to Dr. Jinahn Kim all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
I certify that all information I have reported above is correct and further authorization for the release of any necessary information to my insurance carrier(s) or referring physician(s). I understand and agree to be responsible for any portions of this claim that, for any reason, is not covered by my insurance. I further understand that any legal fees incurred to collect this claim are my responsibility as well as any service charges assessed to my account with all returned checks or invalid credit card purchases. All balances must be paid upon receipt of statement, and should the balance due exceed 15 days from the initial statement date. A finance charge of 1.5% per month will be charged on the unpaid balance. If the balance is not paid within 30 days from the initial statement, then the account will be considered as delinquent and will be turned over to a collection agency, and will be responsible for financial charges. If the balance is still not being paid within 45 days, then further collection and legal action will be enforced, and the patient is responsible for all related legal fees in addition to the balance due.

앞의 내용은 보험 처리가 안 되는 병원비에 대해서 환자분의 책임을 묻는다는 내용입니다.

아래에 서명하여 주시기 바랍니다.

THE PROCEDURES NOT COVERED BY INSURANCE IS PATIENT'S RESPONSIBILITY.
PLEASE SIGN BELOW.

x_____ _____
환자서명/Patient's Signature 날짜/Date

18 세 미만 환자는 아래사항을 반드시 기입하십시오.
If patient is under 18, please sign below.

_____ **x**_____
보호자 성명/Guardian's Name 보호자 서명/Guardian's Signature

_____ _____
환자와의 관계/Relationship with patient 날짜/Date

Privacy practices acknowledgement

I understand that my health information can be used without my permission under the following conditions: Treatment, Payment, Health-Care Operations, Business Associates, Appointment Reminders, Health-Related Benefits, Services and research, Required Disclosures, Required by Law, Public Health and Safety, Abuse and Neglect, Health Oversight Activities, Legal Proceedings, Law Enforcement, Coroners, Medical Examiners and Funeral Directors, Organ and Tissue Donation, Research. All Other uses and sharing of your health information will be done only with your written permission. You also have Right to Request Special Communications, Right to Inspect and Copy, Right to Request Changes, Right to an Accounting of Disclosures, and Right to Request Restrictions.

앞의 내용은 귀하의 의료기록이 치료 또는 보험청구 목적에 따라 귀하의 허가 없이 사용될 수 있으며 귀하는 귀하의 의료기록을 볼 수 있는 권한이 있음을 알려드립니다.

_____ _____

환자성명/Patient Name (Please Print) 생년월일/Date of Birth

_____ _____

환자서명/Signature of Patient 날짜/Date

Consent of Obtaining External Prescription History

I,_____, whose signature appears below, authorize JK Internal Medicine & Geriatrics to obtain my external prescription history. I understand that my providers and staff here have access to prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy and it may include prescription back in time for several years.

앞의 내용은 귀하의 처방기록을 다른 병원, 보험회사, 약국 등에서 받을 수 있음을 알려드립니다.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

x_____ _____

환자서/Patient's Signature 날짜/Date

18 세 미만 환자는 아래사항을 반드시 기입하십시오.

If patient is under 18, please sign below.

_____ **x**_____

보호자 성명/Guardian's Name 보호자 서명/Guardian's Signature

_____ _____

환자와의 관계/Relationship with patient 날짜/Date