Specialty Medical Center/ Mark M. song, M.D.,Ph.D.

Patient Information for Medical Records

*Please Print Clearly Today's Date(오늘 날짜):_____

Patient Name(환자 성함-영문과 한글):_____

Social Security Number(쇼셜번호):_____Gender(성별):Female(여자)/Male(남자)

Birthdate(생년월일):_____Age(나이):_____

Marital Status(결혼사유): Single(미혼)___Married(결혼)___Divorced(이혼)___Seperated(별거)___Widowed(사별)___

Home Address(집주소):_____

_____

City(시) State(주) Zip Code(우편번호)

Home Phone(집 전화번호): ( )_____Cell Phone(휴대폰 번호): ( )_____

Email Address(이메일주소):_____

Employer's Name(직장 이름):_____

Position(직위):_____Work Phone(직장 번호): ( )_____

Work Address(직장 주소):_____

Insurance Subscriber or Responsible Party

Insured Name(이름):_____Relationship(관계):_____

Identification or Subscriber Number(보험가입번호):_____

*Copy (Front & Back) of the Insurance Card is made ( )

Pharmacy Name(약국이름):_____

Phone Number(전화번호):_____ Fax Number(팩스번호):_____

Emergency Contact(s) (응급연락처)

Name(이름): _____ Relationship(관계):_____

Home Phone(집 전화번호):_____ Cell Phone(휴대폰 번호):_____

I, the undersigned, have insurance coverage(s) with _____

Name of Insurance Company

and assign directly to Specialty Medical Center / Dr. Mark M. Song all medical benefits, if any otherwise payable to me for services rendered. I fully understand tha I am financially responsible for all charges whether or not paid to my insurance coverage(s). I hereby authorize the doctor to release all information to secure the payment of benefits.
I authorize the use of the below signature on all my insurance claims submissions.

Print Name(성함):_____Signature(싸인):_____

Relationship(관계):_____

If the patient is minor, the parent or guardian should sign on behalf of the patient.

SPECIALTY MEDICAL CENTER / MARK M SONG, M.D., Ph.D.

PATIENT'S MEDICAL HISTORY RECORD

Patient Name (환자 성함): _____ Gender (성별): _____Male (남) _____Female(여)

Date of Birth (생년월일): _____ Medical Record No. (병원기록번호):

Are you allergic to any medications (약에 부작용이 있으십니까?): _____Yes (예) _____No (아니요)

If Yes, what type of allergies do you have and what are their reactions?
(만일 알레르기가 있으시다면 어떤 종류이며 반응 또는 증상이 어떠합니까?)

Do you have any food allergies? (음식에 알레르기가 없으십니까?) Yes No

	Yes(예)	No(아니요)	Treatments and/or Surgeries (치료와 수술 기록)
Cataract(백내장)			
Diabetes(당뇨)			
Hypertension(고혈압)			
Heart Disease(심장질환)			
Asthma(천식)			
Tuberculosis(결핵)			
Stomach Problems(위장질환)			
Intestinal Problems(장질환)			
Hepatitis(간염)			
Any other liver diseases(간질환)			
Kidney Diseases(신장질환)			
Kidney Stone Disease(신장결석)			
Bladder Infection(방광염)			
Thyroid Disease(갑상선)			
Spinal Disease(척추질환)			
Cancer(암)			
Stroke(중풍)			
Seizure(간질)			

Have you ever been hospitalized? (병원에 입원하신적이 있이십니까?) _____Yes (예) _____No (아니요)

Have you ever had blood transfusion? (피 수혈을 받이신적이 있으십니까?) _____Yes (예) _____No (아니요)

Are you taking any medication(s)? (지금 복용하시는 약들이 있으십니까?) _____Yes (예) _____No (아니요)

If you answered yes to any of above questions, please list them below.
(만일 위의 질문에 '예'라고 답을 하셨다면, 아래에 기재하십시요.)

_____

_____

_____

In you immediate family, anybody has medical conditions? _____Yes (예) _____No (아니요)
(직계 가족이나 친척들중에 병력이 있으신 분이 있으십니까?)

Have you been smoking? (흡연을 하신적이 있으십니까?) _____Yes (예) _____No (아니요)

Have you been drinking alcohol? (음주를 하신적이 있으십니까?) _____Yes (예) _____No (아니요)

Have you been using drug? (마약을 하신적이 있으십니까?) _____Yes (예) _____No (아니요)

If you answered yes to any of above questions, please list them below.
(만일 위의 질문에 '예'라고 답을 하셨다면, 아래에 기재하십시요.)

_____

_____

_____

Patient (Guardian) Signature: _____ Date: _____

MARK SONG, M.D., Ph.D.
1401 S. BROOKHURST RD., SUITE 100
FULLERTON, CA 92833
(714) 626-0700

Patient Name: _____

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

This notice describes how patient protected health information may be used and disclosed and the patient's right to access to this information.
Please review carefully.

The ***Health Insurance Portability & Accountability Act of 1996*** ("HIPPA") requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse personal health information is subject to penalties.

- We may use and disclose patient medical records only for the following purposes:
  - **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers.
  - **Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review (e.g., billing insurance provider for patient visit)
  - **Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management services and as required by law
- We may create and distribute non-identified health information by removing all references to individually identifiable information.
- We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
- Any other uses and disclosures may be made only with patient's written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.
- We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.
- Patients have the following right with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:
  - The right to request restriction on certain uses and disclosures of protected health information, including those related family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless a patient agrees in writing to remove it.
  - The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.

_____ _____

Patient (Guardian) Signature Date