Dr. Hidenao Kimura
Registration Form

Patient Information

Last Name:		First:	Middle Initial:
Street Address:			Apartment/Unit #:
City:	State:	Zip:	DOB:
Home Phone: ( )		Cell Phone: ( )	
Work Phone: ( )		E-mail Address:	
Social Security No:	Driver's License:	Gender Identity: ☐ Male ☐ Female ☐ Other (please specify): _____	
Referred by: ☐ Family ☐ Friend ☐ Close to home/work ☐ Other:_____		Ethnicity: ☐ White ☐ Hispanic ☐ Asian ☐ African American ☐ Native American	
Emergency Contact:	Relationship:	Emergency Contact Phone: ( )	

Insurance Information

Primary Insurance Company:		Secondary Insurance: Company:	
Insured ID:		Insured ID:	
Insured Name (if other than patient):		Insured Name (if other than patient):	
Insured Gender: ☐Male ☐ Female ☐ Other (please specify): _____		Insured Gender: ☐Male ☐ Female ☐ Other (please specify): _____	
Insured Date of Birth:	Insured Social Security No:	Insured Date of Birth:	Insured Social Security No:

Person Financially Responsible For This Patient If Other Than Patient

Last Name:		First:	Middle Initial:
Street Address:			Apartment/Unit #:
City:	State:	Zip:	DOB:
Home Phone: ( )		Cell Phone: ( )	
Work Phone: ( )		E-mail Address:	
Social Security No:		Driver's License:	
Relationship to patient: Parent Guardian			

Signature of Patient Or Legal Parent/Guardian

Signature:	Date:

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

DR. HIDENAO KIMURA, M.D.
REGISTRATION FORM

(Please Print)

As a service to our patients, we would like to outline our policy regarding the payment for service.

1. Twenty-four (24) hour notice of cancellation of appointment is required. There will be a charge of $100 (not covered by insurance) for a no-show physical exam or new patient consult. There will be a charge of $40.00 (not covered by insurance) no-show for other office visits.
2. Payment for the first office visit may be expected for all new patients. Payment on established account is due every 30 days by Health insurance or the responsible party (patient, parent, or legal guardian.) All insurance companies are billed as a courtesy to you, you are responsible for your account.
3. If the issue for you which you are seeing the doctor involves litigation, such as may result from an automobile accident, be advised that we do not wait for payment until litigation is settled.
4. Your signature authorizes us to contact references listed below if it becomes necessary to locate you.
5. All credit balances may be held as credits against future services rendered unless credit refunds are specifically requested.
6. We encourage you to contact our billing department if you have any questions regarding your account.
7. Patients are responsible for checking coverage for office visits through their insurance plan, before coming in.

I HEREBY AUTHORIZE THE ABOVE DOCTOR TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT CLAIM. I HEREBY ASSIGN TO THE DOCTOR ALL MONEY TO WHICH I AM ENTITLED FOR EXPENSE RELATED TO THE SERVICE PERFORMED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR FOR CHARGES NOT COVERED BY THE ASSIGNMENT.

RESPONSIBLE PARTY'S SIGNATURE			
Patients Last Name, First Name:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Hidenao Kimura, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

AT DR. KIMURA'S OFFICE, THE PATIENT HAS THE FOLLOWING RIGHTS

- To be treated with courtesy and respect with appreciation of their individual dignity, and with protection of their need for privacy
- To prompt, reasonable response to care needs, questions, and requests
    - Business hours: M, T, Th, F 7:30 am-4:30 pm, Wednesdays 7 am-12:30 pm
    - After hours advice: 503-612-1181
- To know who is providing healthcare services and who is responsible for their care
- To an interpreter if they do not speak English
- To be given, by the healthcare provider, information regarding diagnosis, planned course of treatment, alternatives, risks, and prognosis
- To refuse any treatment, except as otherwise provided by law
- To receive, upon request, prior to treatment, a reasonable estimate of charges for healthcare
- To receive a copy of a reasonably clear and understandable itemized bill, and upon request, to have the charges explained
- To impartial access to healthcare treatment or accommodations regardless of race, national origin, religion, physical handicap, or source of payment
- To express grievances regarding any violation of their rights through Dr. Kimura's grievance procedure and to the appropriate state licensing agency
    - Clinic contact for grievances: Hidenao Kimura, MD, 503-612-1181
    - Oregon contact for grievances: Health Care Licensure and Certification Division, 971-673-0540

THE PATIENT HAS THE FOLLOWING RESPONSIBILITIES

- To provide Dr. Kimura's office, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to their health
- To report to the clinic provider unexpected changes in their condition
- To report to the clinic provider whether they understand recommended treatment and what is expected of them
- To follow the treatment plan recommended by the clinic provider
- To keep appointments, and when they are unable to do so for any reason, to notify the clinic
- A patient is responsible for their actions if they refuse treatment or do not follow the clinic provider's instructions
- To assure that the financial obligations of their healthcare are fulfilled as promptly as possible
- To follow the clinic rules affecting patient care and conduct

PATIENT SIGNATURE: DOB: DATE:

HIDENAO KIMURA

19365 SW 65th Ave. Suite 111
TUALATIN, OR 97062
PHONE: (503) 612-1181
FAX: (503) 612-1182

I, _____, give consent for Dr. Kimura to request and receive medical information on my behalf, for my overall health, via Commonwell and HIE with other providers and facilities.

I understand that the information shared between providers and facilities is protected and confidential through HIPAA, and with my consent my health needs are better served.

PATIENT SIGNATURE:_____

PATIENT D.O.B: _____/_____/_____

DATE:_____/_____/_____

DR. HIDENAO KIMURA
19365 SW 65TH AVE. SUITE 111
TUALATIN, OR 97062
PHONE: 503-612-1181
FAX: 503-482-4504

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, (Name)_____ DOB: _____

Patient Address:

_____

Authorize:

(Name of Physician)_____ (Phone)_____(FAX)_____

To provide Dr. Hidenao Kimura. MD 19365 SW 65th Ave. Suite 111 Tualatin. OR 97062

The information **(two years worth)** to be released:

_____

Purpose or need for information requested:

Continue Care _____ Insurance _____ Legal _____Transfer _____ Personal _____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by witten, dated, and signed communicauon. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

Signature _____ Relationship _____ Date_____

A copy of this authorization has been _____ accepted _____ rejected by the patient/representative.

A photocopy of this authorization will be considered valid unless otherwise specified.

_____

Office use only: