HIDENAO KIMURA, M.D.

Intake and Registration

Patient Information

First Name : | Middle : | Last Name :

Street Address :

Zip Code : | City : | Country :

Primary Phone Number : ☐ Home ☐ Work ☐ Mobile

Secondary Phone Number : ☐ Home ☐ Work ☐ Mobile

Social Security # : | Driver's License ID:

Birth Date (mm/dd/yyyy):

Birth Sex : ☐ Male ☐ Female

Race : ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black ☐ Asian ☐ White ☐ Other :

Ethnicity : ☐ Hispanic

Email :

Preferred Language : ☐ English ☐ Other :

Gender Identity : ☐ Male ☐ Female ☐ Other :

Is the financially responsible person same as the patient?
☐ Yes
☐ No (please fill out their information on page 2)

Insurance Information

Primary Insurance Company :

ID # : | Group # :

Fill out below if insured name is other than the patient

Insured Name: | Insured DOB: | Insured Soc Sec # :

Secondary Insurance Company :

ID # : | Group # :

Fill out below if insured name is other than the patient

Insured Name: | Insured DOB: | Insured Soc Sec # :

Emergency Contact

Name : | Relationship : | Phone :

Financially Responsible Person (Fill this out if they are not the patient)

First Name :	Middle :	Last Name :
Street Address :		
Zip Code :	Country :	
Primary Phone Number :	◯ Home ◯ Work ◯ Mobile	
Social Security # :	Driver's License ID:	
Relationship to patient :		

Patient financial obligation agreement

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 fi 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 AL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT CLAIM. I HEREBY ASSIGN TO THE DOCTOR ALL MONEY TO WHICH IAM 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.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the Privacy Practice Acknowledgement

☐ I have been provided a copy

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.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Patient and Insurance information).

Patient or Legal Guardian Name Printed :

Patient or Legal Guardian Signature:

Date:

Patient Name: DOB:

Today's Visit

Reason for today's visit :

☐ Physical Exam ☐ Establish PCP

General Medical Questionnaire

Disease/Condition	Current/Past *(leave blank if not applicable)*	Comments
Alcoholism/Drug Abuse	☐ Current ☐ Past	
Asthma	☐ Current ☐ Past	
Cancer (type :)	☐ Current ☐ Past	
Depression/Anxiety/Bipolar/Suicidal	☐ Current ☐ Past	
Diabetes (type :)	☐ Current ☐ Past	
Emphysema (COPD)	☐ Current ☐ Past	
Heart Disease	☐ Current ☐ Past	
High Blood Pressure (hypertension)	☐ Current ☐ Past	
High Cholesterol	☐ Current ☐ Past	
Hypothyroidism/Thyroid Disease	☐ Current ☐ Past	
Renal (kidney) Disease	☐ Current ☐ Past	
Migraine Headaches	☐ Current ☐ Past	
Stroke	☐ Current ☐ Past	
Other:	☐ Current ☐ Past	
Other:	☐ Current ☐ Past	

Additional Comments

Allergies *(Please List Medication Allergies first)* ☐ No Allergies

Allergy	Allergic Reaction

Patient Name:	DOB:

Medications

☐ No Medications

Medications *(Please list all, if not enough space, please write them on a blank sheet of information)*	Dose *(mg, pill, etc)*	Times per day

Health Maintenance Screening Test History

Cholesterol	Date:	Abnormal Result?	☐ Y	☐ N
Colonoscopy	Date:	Abnormal Result?	☐ Y	☐ N
Mammogram	Date:	Abnormal Result?	☐ Y	☐ N
Pap Smear	Date:	Abnormal Result?	☐ Y	☐ N
Bone Density	Date:	AAbnormal Result?	☐ Y	☐ N

Vaccination History

Last Tetanus booster	Aprox. when:
Last Flu Vaccine	Aprox. when:
Last Shingles Vaccine	Aprox. when:
Last Pneumovax	Aprox. when:
Last Prevar	Aprox. when:
Last Covid Vaccine	Aprox. when:

Social History

Occupation (or prior)	
Marital Status	☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed ☐ Other:
How many children do you have? ("0" for none)	

Surgeries *(Surgeries in the last 5 years + any major surgeries)*

☐ No surgeries

Type *(Please specify Left or Right when applicable)*	When	Facility/Provider

Women Health History

☐ Not Applicable

Date of Last Menstrual Cycle:	Age of First Menstruation:
Total Number of Pregnancies:	Age of Menopause:
Number of Live Births:	Pregnancy Complications:

HIDENAO KIMURA, M.D.

Health History

Patient Name:	DOB:

Tobacco Use

☐ Not Applicable

Current Pack/Day: # of Years :	Past: Pack/Day: # of Years :
Other Tabacco use?	☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol/Drug

☐ Not Applicable

☐ Beer ☐ Wine ☐ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? ☐ Y ☐ N	Have you ever used needle to inject drugs? ☐ Y ☐ N
Have you ever taken someone else's drug? ☐ Y ☐ N	

Sexual activity

☐ Not Applicable

Sexually involved currently? ☐ Y ☐ N	Sexual partner (s) is/are/have been: ☐ Male ☐ Female
Birth control method: ☐ None ☐ Condom ☐ Pill/Ring/Patch/inj/IUD ☐ Vasectomy	

Other Health information

Exercise Regularly? ☐ Y ☐ N	What Kind: How often:
How many hours of sleep :	Sleep Quality : ☐ Good ☐ Fair ☐ Poor
How would you rate your diet? ☐ Good ☐ Fair ☐ Poor	Would you like advice on your diet? ☐ Y ☐ N
Safety Is violence a concern for your home? ☐ Y ☐ N	

Family Health History ("X" All that apply)

	Alcohol/Drug Abuse	Asthma	Cancer	COPD	Depression/anxiety	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother *(on your mom side)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather *(on your mom side)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother *(on your dad side)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather *(on your dad side)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional Comments on Family History (Please Also use this space to specify the type of cancer)

Patient Name: DOB:

Review of systems (Please check "x" all that applies)

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis		GASTROINTESTINAL		Wound
	Fatigue		Abdominal distention		ALLERGY/IMMUNO
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
	HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		NEUROLOGICAL
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling		ENDOCRINE		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure		GENITOURINARY		HEMATOLOGIC
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis		PSYCHIATRIC
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
	RESPIRATORY		Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness		MUSCULAR		
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name:	DOB:

Other providers and specialists

☐ No Other Provider

Specialist	Name	Last Visit
Cardiology		
Gastroenterologist		
OB/GYN		
Neurology		
Pulmonary		
Other:		

At Dr. Kimura's Office, The patient has the following Rights and responsibilities

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 8 am-4:30 pm, Wednesdays 7am-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
- 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 or Legal Guardian Signature:

Date:

HIDENAO KIMURA, M.D.

Patient Name:	DOB:

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 communication. 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:

HIDENAO KIMURA, M.D.

Patient Authorization to Release Medical Record

Patient Name:	DOB:

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

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:_____/_____/_____

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐