THOMAS H. RHEE, M.D., P.C.
PATIENT INFORMATION

PATIENT NAME (Last, First, MI) _____

Social Security Number: _____ Date of Birth: _____
Sex: M / F Marital status: Single / Married / Divorced / Separated / Widow

Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Daytime phone:( ) _____ Work:( ) _____ Ext: _____
Alternative Phone:( ) _____ Email Address: _____
Emergency Contact: _____ Phone:( ) _____
Referred by Dr. : _____ Phone:( ) _____

If a Minor: Responsible Party Name: _____ Date of birth: _____
Resp Party Social Security Number: _____ Phone:( ) _____
Resp Party Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____
Patient's relationship to Subscriber: Self / Spouse / Child / Other: _____
Subscriber Name: _____ Date of Birth: _____
Sex: M / F Insurance ID# : _____ Group# : _____
Employer Name: _____ Phone:( ) _____
Subscriber Address (if different from above): _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____
Patient's relationship to subscriber: Self / Spouse / Child / Other: _____
Subscriber Name: _____ Date of Birth: _____
Sex: M / F Insurance ID# : _____ Group# : _____
Employer Name: _____ Phone:( ) _____
Subscriber Address (if different from above): _____

Payment Policy: We will verify your insurance benefits prior to being seen. Payment for your office visit copayment, deductible and/or coinsurance will be collected at the time of the visit. There will be a $10.00 fee added to your account if not paid at that time. All charges in conjunction with your visit will be submitted to your insurance and may generate an additional bill to you. This includes but is not limited to allergy testing, endoscopes, surgical procedures, hearing tests, etc. performed in our office. There is a $30.00 bank fee for returned checks. If your account is turned over for collection activity due to non-payment of your account, you are responsible for all attorney fees and court costs. Please call 24 hours in advance if you are unable to keep your scheduled appointment. There is a $30.00 fee for missed appointments not cancelled. There is a $25.00 fee for copying medical records not requested by another physician. I authorize the release of any medical benefits to this provider. I authorize release of all pertinent medical records to Dr. Thomas H. Rhee as necessary.

Patient/Guardian Signature: _____ Date: _____

PLEASE COMPLETE BACK OF FORM

THOMAS H. RHEE, M.D., P.C.
D SUITE 1B
MANASSAS VA 208703 STONEWALL R110
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

: Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

: Obtain payment from third-party payers.

: Conduct normal healthcare operations such as quality assessments and physician certificates.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain, a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken, again relying on this consent.

I understand that I may advise you of the individuals you are to release my PHI to.

**These are the individuals you may advise of my PHI:_____

_____

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

(MEDICAL RED FLAG RULE) Please provide the answers to the security questions listed below IF PATIENT OR GUARDIAN DOES NOT HAVE A VALID PHOTO ID:

1) What is your mother's maiden name:_____

2) What is your father's middle name:_____

3) What city were you born in:_____

Patient History

Date:

Patient Name: _____ Age: _____ DOB_____

Reason for your visit? _____

Have you had any imaging done related to this visit? Yes / No (CT/MRI etc.)

Is this an injury? Yes / No Date of the Injury? _____

Patient Height (inches): _____ Weight: _____

Circle all medical problems you have

Diabetes High Blood Pressure Asthma COPD Sleep Apnea Heart Disease

Other: _____

Are you allergic to any medications? Yes / No If so, please list all drug allergies and reaction

_____

_____

_____

Are you currently taking any medications? Please list

_____

_____

_____

Are you a smoker? _____ Never smoker _____ Former smoker _____ Current smoker

Do you drink alcohol? Yes / No If so circle if: Occasional / Daily

Have you had any surgical procedures? Please list all and approximate year

_____ **Year:** _____

_____ **Year:** _____

_____ **Year:** _____

_____ **Year:** _____

WHAT IS YOUR PHARMACY OF CHOICE: _____

Family Medical History. Does anyone in your family have the following? Please circle & indicate who.

Bleeding disorder Grandfather/ Grandmother/ Father/ Mother / Siblings/ Child

Blood Pressure Grandfather/ Grandmother/ Father/ Mother / Siblings/ Child

Cancer Grandfather/ Grandmother/ Father/ Mother / Siblings/ Child

Diabetes Grandfather/ Grandmother/ Father/ Mother / Siblings/ Child

Heart Disease Grandfather/ Grandmother/ Father/ Mother / Siblings/ Child

Other not listed: Grandfather/ Grandmother/ Father/ Mother / Siblings/ Child

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Review of symptoms. Please circle all that apply.

GENERAL: Chills, Fever, Sweats

EYES: Reading Glasses

RESPIRATORY: Cough, Sputum, Wheezing / Asthma

DIGESTIVE SYSTEM: Abdominal pain, Frequent Belching Heartburn

URINARY SYSTEM: **FEMALE:** Irregular Period, Difficulty Urinating
MALE: Waking Nightly to Urinate

NERVOUS SYSTEM: Seizures, Numbness/Tingling, Strokes

BLOOD/LYMPH SYSTEM: Easy Bleeding

HEAD: Frequent Headaches

EARS/NOSE/MOUTH:
Loss of Hearing, Ringing in Ears, Sinus Pressure, Stuffiness, Nasal Drainage, Hoarseness, Difficulty Swallowing, Throat Pain, Snoring, Vertigo

HEART: Elevated Cholesterol

MUSCLES/BONES: Weakness, Degenerative Disease

SKIN: Skin Cancer, Non-Healing Lesion

ENDOCRINE/GLANDS: Thyroid Problems, Diabetes

ALLERGIES: Hay Fever, Environmental