DRS. KANE, MISAWA & NGUYEN, LLC

GASTROENTEROLOGY
www.mygastrodocs.com

Mary G. Kane, M.D.
Kyoko Misawa, M.D.
Phithao J. Nguyen, D.O.

Please complete the attached forms and send back prior to your appointment. Also include a copy of the front and back of your insurance cards.

- Mail: 33 W. Higgins Rd. Suite 820 South Barrington, IL 60010
- Fax: 847-426-0047
- Email

Medication List

Date: / / Patient Name: DOB: / /

This list should include all prescribed medications, aspirin, over the counter medications, herbs and health supplements.

Name	Strength	Frequency	Reason

Phone: 847-426-4355 Fax: 847-426-0047

33. W. Higgins Road
Suite 820
S. Barrington, IL 60010

800 W. Biesterfield Road
Wimmer Plaza, Suite 101
Elk Grove Village, IL 60007

880 W. Central Road
Busse Center, Suite 8100
Arlington Heights, IL 60005

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Patient Name____ Date of Birth____________

Address______________________________ City________________ State____ Zip________

Home Phone_____________ Cell Phone______________ Email_______________________

Sex___Social Security#__________Marital Status____Pharmacy name/ph#__________________

Employer _____________________Drivers License#____________ Language____________

Race(please circle) African American Asian Caucasian Hispanic/Latino Other Refused

PLEASE BRING ALL INSURANCE CARDS & PHOTO ID

Primary Insurance_____________________ Group#____________ I.D.#_________________

Address______________________________ City________________ State____ Zip________

Responsible Party ____________________Relation to you ____________ Date of Birth________

Responsible Party Social Security#________________ Responsible Party Employer ____________

Secondary Insurance_____________________ Group#___________I.D.#_________________

Address______________________________ City________________ State____ Zip________

Responsible Party ____________________Relation to you ____________ Date of Birth________

Responsible Party Social Security#________________ Responsible Party Employer ____________

Doctor Who Referred You/ Primary M.D.________________ Purpose of Visit_________________

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to: Drs. Kane, Misawa & Nguyen, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I am responsible for following my insurance policy protocol and will accept any penalties incurred.

Signed____ Date________________

Phone: 847-426-4355 Fax: 847-426-0047

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Patient name: ______________________________

PERSONAL HISTORY

Marital Status______
Do you smoke?____ How much?_________
If no, did you ever smoke?_______

Occupation ______________________
Do you consume alcohol? ____________
If yes, how much? ________________

FAMILY HISTORY

Mother: Living or Deceased
Illnesses: ____________________________
____
____
Cause of death: ________________________
____
Age at death: ________

Brothers:
Illnesses: ____________________________
____
____
Cause of death: ________________________
____
Age at death: ________

Father: Living or Deceased
Illnesses: ____________________________
____
____
Cause of death: ________________________
____
Age at death: ________

Sisters:
Illnesses: ____________________________
____
____
Cause of death: ________________________
____
Age at death: ________

Has anyone in your extended family (parents, siblings, children, cousins, grandparents, etc.) had any of the following:

Yes	No		Relation
[ ]	[ ]	Ulcers	__________________
[ ]	[ ]	Pancreatitis	__________________
[ ]	[ ]	Gallstones	__________________
[ ]	[ ]	Hepatitis	__________________
[ ]	[ ]	Cirrhosis	__________________
[ ]	[ ]	Crohn's disease	__________________
[ ]	[ ]	Ulcerative Colitis	__________________

Cancer of the:

Yes	No		Relation
[ ]	[ ]	Esophagus	__________________
[ ]	[ ]	Stomach	__________________
[ ]	[ ]	Colon	__________________
[ ]	[ ]	Pancreas	__________________
[ ]	[ ]	Liver	__________________
[ ]	[ ]	Breast	__________________
[ ]	[ ]	Ovarian	__________________
[ ]	[ ]	Uterine	__________________

CURRENT SYMPTOMS

Do you have stomach pain? ________ Please explain: ______________________________
____
Have you ever vomited blood or passed blood in your stools? ______________________
____
How many bowel movements do you have a day? ______________________________

Do you have trouble with any of the following?

Yes	No		Explain
[ ]	[ ]	Eyes	__________________
[ ]	[ ]	Ears	__________________
[ ]	[ ]	Nose	__________________
[ ]	[ ]	Chest/lungs	__________________
[ ]	[ ]	Heart	__________________
[ ]	[ ]	Weight loss/fever	__________________
[ ]	[ ]	Arms & legs	__________________
[ ]	[ ]	Back	__________________
[ ]	[ ]	Vaginal bleeding	__________________
[ ]	[ ]	Urination	__________________
[ ]	[ ]	Headaches/seizures	__________________
[ ]	[ ]	Anxiety/depression	__________________

Patient name: ______________________________

MEDICAL BACKGROUND

PAST MEDICAL HISTORY

Allergies: ______________________________

Operations (type and year): ______________________________

____

____

Hospitalizations (diagnosis and year): ______________________________

____

____

Other medical problems (type and year): ______________________________

____

____

HAVE YOU EVER HAD:

Yes	No	
[ ]	[ ]	Ulcers
[ ]	[ ]	Pancreatitis
[ ]	[ ]	Hepatitis
[ ]	[ ]	Cirrhosis
[ ]	[ ]	Crohn's disease
[ ]	[ ]	Ulcerative colitis

CANCER OF THE:

Yes	No	
[ ]	[ ]	Esophagus
[ ]	[ ]	Stomach
[ ]	[ ]	Colon
[ ]	[ ]	Liver
[ ]	[ ]	Pancreas
[ ]	[ ]	Breast
[ ]	[ ]	Ovarian
[ ]	[ ]	Uterine
[ ]	[ ]	Other: __________

VACCINATIONS
(date if taken):

_________Oral Polio
_________Tetanus
_________Pneumonia
_________Flu

PREVENTIVE HEALTH CARE

Date		Results
__________	Rectal exam	______________________________
__________	Proctoscopy	______________________________
__________	Stool for blood test	______________________________

No. of children: ___________

GYNECOLOGIC

No. of pregnancies: ____________

Form of birth control used: ______________________________

Are your periods regular? ______________________________

Most recent:

Date		Results	Date		Results
______	Pap Smear	___________________	_______	Mammogram	_________________
______	Breast Exam	_________________	_______	Period	______________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. 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 certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Drs. Kane, Misawa & Nguyen, LLC to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private 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 you are bound to abide by such restrictions.

Do we have your permission to leave medical information on your answering machine at
Home? _______ Work? _______
Do we have your permission to discuss personal medical care/information with other individuals?

Name/Names	Relationship	Phone
______________________	______________________	______________
______________________	______________________	______________

Our Regular Business Hours are:	Monday thru Thursday	8:30 am to 5:00 pm
	Friday	9:00 am to 12:00 pm

Call during these hours for appointments, medication renewals, and routine symptoms or medical questions.
For any medical emergencies after business hours, please call 847-758-2921. The service will take your message and give it to the doctor on call.

* After you have any tests done that the doctor ordered, please contact the office staff so we can get the results. Do not assume "no news is good news." Sometimes we do not receive the result; we need your call so we can be certain that we see all test results.
* If you decide to decline the recommendations of the doctors, or choose not to have tests or take prescribed medicines, please call the office and inform the office staff so that we can note this in your record.

I have read and received a copy of the above:

Patient Name: ____

Signature: ______________________________ Date: ______________________