IN KWON PARK, MD Internal Medicine, Infectious Diseases
8730 S Tacoma Way Suite 104 Tacoma, WA 98499 Ph: (253) 212-3637, Cell: (253) 363-6514, Fax: (253) 267-0153

NEW PATIENT REGISTRATION

The obtained information will be kept confidential and used only for your medical care purposes accordingly to the HIPAA Privacy Rules and Joint Commission Requirements.

- Patient Information

Social Security Number: ( )
First Name:_____ Last Name:_____ Middle Initial:_____
Birth Date (MM/DD/YYYY):_____ Gender: M( ) F( )
Address: _____
Street City State Zip
Phone: (Home)_____(Cell)_____ (Work)_____
E-mail:_____
Would you like appointment reminders/correspondences of your medical information in your voice mail, answering machine or text message?: Yes ( ) No( )

Emergency Contact, Family member or legal guardian:
First Name:_____ Last Name:_____ Middle Initial: _____
Phone(Cell):_____ Relationship: _____
Do you allow us to communicate regarding your medical information with above person?
Yes ( ) No ( )

- Insurance Information

Primary Insurance Company: _____ Member ID #:

Group #:_____Relationship to Insured: Self ( ) or Other _____

Secondary Insurance Information:

Please present your INSURANCE CARD(s) and your photo ID to the receptionist along with this completed form. The receptionist will make a copy and return them to you promptly.

IN KWON PARK, MD Internal Medicine, Infectious Diseases
8730 S Tacoma Way Suite 104 Tacoma, WA 98499 Ph: (253) 212-3637, Cell: (253) 363-6514, Fax: (253) 267-0153

PATIENT MEDICAL INFORMATION/ HISTORY

Please check ✓*current* and *past* problem

__Diabetes. High blood pressure

__High cholesterol. Stroke

__Heart diseases Liver diseases

__Kidney diseases Thyroid diseases

__Lung disease

__ Blood clotting disorder

__Urinary tract Bladder diseases

__Joint Problem

__Epilepsy

__History of pneumonia

__History of tuberculosis infection

If yes, when? _____

__Cancer (type): _____

__Stomach or intestinal diseases:

Last Endoscopy:

Last Colonoscopy:

Last Blood Test:

__Smoking:___Current(Years) ___Quit

__Alcohol:____Occasional ___ Often

___Any previous hospitalization

If yes, when and for what condition?

_____

_____

__Any surgery

If yes, when and what kind of surgery?

_____

Family Medical History:

_____

_____

Other medical conditions:

_____

_____

Allergies to any medications/food:

_____

_____

Agreement

I understand if I am wanting to be seen for a **preventative/annual wellness visit** it is my responsibility to notify the provider and staff prior to the start of my exam, otherwise it will be billed as a new patient visit and I will be responsible for the amount owed dependent on my insurance and plan.

I understand that In Kwon Park, MD does not treat the following conditions but will aid in finding a properhealth care facility specialized in these conditions:

- Chronic pain that requires a long-term opioid pain medication
- Trauma due to a motor vehicle accident (MVA)
- Trauma due to an injury sustained at a work site (Labor and Industries case)
- Attention-Deficit Hyperactivity Disorder (ADHD)

I allow IN KWON PARK, MD PLLC to get payments directly from my medical insurance/plans for the servicesrendered and pay any co-payment at the time of service.

I hereby certify that the information I provided is correct to the best of my knowledge and agree to the above conditions

Printed Name : **Date:**

Patient or Legal Guardian Signature:

Medical Records Release Form

By signing this form, I authorize to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician (In Kwon Park, MD) office.

Name: _____ DOB: _____

Signature: _____ Date: _____

In Kwon Park, MD (Internal Medicine, Infectious Diseases)
8730 S Tacoma way #104 Lakewood, WA 98499
P: (253) 212-3637 F: (253) 267-0153

11216 Sunrise Blvd. E, STE3-104 Puyallup, WA 98374
P: (253) 271-0384 F: (253) 271-7539

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

---

Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient	
Address	
Phone Number	E-mail
Date of Birth	

Name of Guardian or Legal Representative	
Relationship with a patient	
Address	
Phone Number	E-mail

I hereby authorize the *In Kwon Park, MD PLLC* to receive all health information about me following the HIPAA Privacy Rules and Joint Commissions Requirements.

FROM: **Name of Previous Primary Care / PCP**		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Type of Information Requested:

☐ Laboratory Results ☐ Imaging Study Results ☐ Progress Notes ☐ Consultation Notes
☐ PT/OT records
☐ Hospital Admission History and Physicals ☐ Hospital Discharge Notes ☐ Entire medical records

Duration: Past ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐ Entire periods available

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

TO: Person/Organization to Receive Information ***IN KWON PARK, MD PLLC***	
Street Address *8730 S Tacoma way #104* *Lakewood, WA 98499*	***Return Fax (253) 267-0153*** *Phone (253) 212-3637*

Patient's or Legal Guardian/Representative's Signature _____ Date _____