

## PATIENT REGISTRATION

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**EMAIL ADDRESS** \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

PLEASE INDICATE AT WHICH NUMBER YOU WOULD LIKE TO BE CONTACTED: \_\_\_\_\_

NAME OF PRIMARY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**PHONE:** \_\_\_\_\_

CONTACT (IN CASE OF EMERGENCY): \_\_\_\_\_

PHONE: \_\_\_\_\_

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HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE) PRIMARY MD/OTHER MD/PATIENT/FRIEND/INTERNET

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### AUTHORIZATION TO TREAT AND RELEASE OF RECORDS

I hereby request and consent to treatment for myself or my child by Marc M. Kerner, MD, Lawrence Pleet, MD, or Designee Physician/Provider.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

I authorize the release of any medical records or other information necessary for the processing of medical claims for myself or my child's behalf. A copy of this form is as valid as the original.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

FINANCIAL INFORMATION

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

INSURANCE INFORMATION:

NAME OF INSURANCE PROVIDER: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

MEDICAL GROUP (IF APPLICABLE): \_\_\_\_\_

POLICY NUMBER(S): \_\_\_\_\_

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**SECONDARY INSURANCE (If applicable)** \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

MEDICAL GROUP (IF APPLICABLE): \_\_\_\_\_

POLICY NUMBER(S): \_\_\_\_\_

CREDIT CARD INFORMATION:

CARD TYPE: V/MC/AMEX                      NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Drs. Kerner, Pleet or their designees to bill my insurance carrier, medical group or other healthcare organization for services provided on my behalf. By placing my initials after the following paragraphs and placing my signature below, I understand that I (or guardian or designee) am financially responsible for my medical care regardless of insurance eligibility or enrollment status at the time services are rendered. This includes any diagnostic services, office-based procedures, and medical management provided to me in the course of my care.

\_\_\_\_\_  
Initials of Patient or Responsible Party

As a courtesy to you we will bill your insurance. If your insurance fails to pay within 30 days of the primary payment, the balance will be forwarded to you or charged to the above credit card.

\_\_\_\_\_  
Initials of Patient or Responsible Party

Appeals: I hereby consent for Marc M. Kerner MD, Inc. to act on my behalf in pursuing any insurance appeals necessary to obtain payment for services rendered. I acknowledge that insurance appeal advocacy does not constitute legal representation, and that I may retain outside legal counsel to participate concurrently, if I so choose.

I understand that if it is determined after any and all medical services are rendered that my eligibility had been terminated by my health plan or medical group, or that the services provided did not have proper authorization, I am financially responsible for all outstanding balances that are accrued. I also acknowledge that I am financially responsible for any and all services rendered that are determined by my health plan or insurance carrier to be either a) a non-covered service; b) medical services that are excluded from my policy for whatever reason; or c) medical services considered by my health plan or insurance carrier to be "cosmetic" in nature and not covered by my policy. I also acknowledge that any outstanding balances not paid within 120 days of services rendered may be turned over to a collection agency which could have an adverse effect on my credit rating.

X  
\_\_\_\_\_  
Signature of Patient / Guardian /Responsible Party

\_\_\_\_\_  
Date

SUMMARY NOTICE OF PRIVACY PRACTICES  
MARC M. KERNER, MD, INC.

This is a summary of our Notice of Privacy Practices, which describes how we may use and disclose your medical and personal information and how you can have access to this information. We have attached a full version of the notice.

OUR PLEDGE TO PROTECT YOUR PRIVACY

Our staff is committed to protecting the privacy of your medical and personal information. So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- to inspect and obtain a copy of your medical records with certain limitations;
- to request an amendment or addendum to your medical record;
- to an accounting of Marc M. Kerner, MD, Inc disclosures of your medical information;
- to request restrictions on certain uses and disclosures of your medical information;
- to request when and where to contact you;
- to request a copy of the full version of this our Notice of Privacy Practices.

WE MAY USE AND DISCLOSE YOUR PERSONAL AND HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSES:

- to provide you with medical treatment;
- to bill and receive payment for the treatment received;
- as required and permitted by law.
- for functions necessary to run Marc M. Kerner, MD, Inc. and assure that our patients receive quality care;
- for public health activities (e.g. reporting abuse);
- for research purposes in limited circumstances;
- to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes;
- to a court or administrative order, subpoena, discovery request or other lawful process;
- to a health oversight agency, such as the California Department of Health Services;

We reserve the right to change our privacy practices and update this Notice accordingly. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices.

For further information about the full Notice of Privacy Practices, please contact our Privacy Officer, Mimi Williams, RN, BSN at (818) 349-0600.

I have read and understood my rights and Marc M. Kerner, MD, Inc. Privacy Standards.

\_\_\_\_\_  
Signature of Patient or Legal Representative  
If Legal Representative, indicate relationship to patient:

\_\_\_\_\_  
Date

## MEDICAL HISTORY

ALLERGIES TO MEDICATIONS OR FOODS: \_\_\_\_\_

PLEASE DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE CONSULTING WITH THE DOCTOR?

CURRENT MEDICATIONS: (PLEASE LIST WITH DOSAGES. INCLUDE VITAMINS, HERBS, HOMEOPATHIC REMEDIES, AND OVER-THE-COUNTER MEDICATIONS ESPECIALLY ASPIRIN OR IBUPROFEN MEDICATIONS):

PLEASE LIST ANY PRIOR SURGERIES WITH DATES:

HAVE YOU EVER HAD DIFFICULTY WITH ANESTHESIA? YES /NO. IF YES, PLEASE DESCRIBE:

PLEASE TELL US ABOUT YOUR CHRONIC MEDICAL PROBLEMS? (PLEASE LIST AND DESCRIBE AS BEST AS YOU CAN)

DO YOU SMOKE Y/N IF YES HOW MUCH? \_\_\_\_\_

IF NO, WHEN DID YOU QUIT? \_\_\_\_\_

ALCOHOL USE: Y/N: \_\_\_\_\_

PLEASE TELL US ABOUT YOUR FAMILY MEDICAL HISTORY IN THE FOLLOWING SPACE PROVIDED:

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS IF THEY APPLY TO YOU, AND USE THE SPACE AT THE RIGHT TO DESCRIBE YOUR ANSWERS IN MORE DETAIL:

### GENERAL MEDICAL CONDITIONS

- ANY RECENT WEIGHT GAIN
- ANY RECENT WEIGHT LOSS
- ANY RECENT USE OF INTRAVENOUS DRUGS
- HISTORY OF SKIN CANCERS
- REACTIONS TO MEDICATIONS
- DIFFICULTY HEALING WOUNDS

### VISION AND HEARING

- GLAUCOMA
- DRY EYE PROBLEMS
- VISION PROBLEMS
- CATARACTS
- HEARING LOSS
- RINGING IN THE EARS
- DIZZINESS
- HISTORY OF EAR SURGERY

MEDICAL HISTORY (continued)

BLOOD DISEASES

EASY BRUISING/BLOOD CLOTTING PROBLEMS  
FAMILY HISTORY OF BLEEDING PROBLEMS  
LYMPHOMA/LEUKEMIA

CARDIAC

SHORTNESS OF BREATH  
HIGH BLOOD PRESSURE  
HEART ATTACK  
IRREGULAR HEARTBEAT  
PACEMAKER

PULMONARY

ASTHMA  
CHRONIC LUNG DISEASES, I.E. EMPHYSEMA:  
SNORING  
SLEEP APNEA  
DAYTIME SLEEPINESS  
DIFFICULTY BREATHING THROUGH NASAL PASSAGES  
CHRONIC RUNNY NOSE  
POSTNASAL DRIP  
LOSS OF SMELL OR TASTE  
RECURRENT SINUS INFECTIONS  
ANY CHANGES IN YOUR VOICE  
HOARSENESS  
COUGHING UP BLOOD

GASTROINTESTINAL SYSTEM

DIFFICULTY SWALLOWING  
REFLUX OF STOMACH ACID  
PEPTIC ULCERS  
ABDOMINAL HERNIAS  
BLOOD IN STOOL  
VOMITING  
CONSTIPATION  
HEPATITIS  
HISTORY OF LIVER PROBLEMS  
JAUNDICE  
GALL BLADDER DISEASE

KIDNEY PROBLEMS

URINARY BLOCKAGE  
KIDNEY STONES  
URINARY TRACT INFECTIONS  
PROSTATE

ENDOCRINE

DIABETES  
THYROID DISORDERS  
EXCESSIVE THIRST  
EXCESSIVE COLD  
FATIGUE

NEUROLOGIC DISEASES

STROKE  
WEAKNESS  
MUSCLE DISORDER  
DEPRESSION  
PSYCHIATRIC DISORDERS

GYN HISTORY:

ONSET OF MENSTRUAL CYCLE? \_\_\_\_\_  
APPROXIMATE DATE OF MENOPAUSE: \_\_\_\_\_  
IRREGULAR CYCLES? Y/N  
COULD YOU BE PREGNANT? Y/N