DR. JEONG OK LEE, M.D. DATE _____/_____/_____

PATIENT INFORMATION

PATIENT NAME ___________________________________ DATE OF BIRTH _____/_____/_____ M or F

Does this patient have any brother(s) or sister(s) coming to our office? YES or NO

If yes, please print name(s)____ ETHNIC GROUP ____________

RESPONSIBLE PARTY ______________________________ RELATIONSHIP TO PATIENT ___________

EMAILADDRESS : ____

FAMILY INFORMATION

MOTHER _____________________ DATE OF BIRTH ____/_____/_____

PHONE # ____)_____-_______ DRIVER'S LICENSE/STATE ID # _______________________________

HOME ADDRESS _____________________________________ CITY_________________ ZIP___________

FATHER _________________________ DATE OF BIRTH ____/____/___

PHONE # ____)_____-_______ DRIVER'S LICENSE/STATE ID # _______________________________

ADDRESS ____ CITY _________________ ZIP __________

PARENTS: ______SINGLE ______MARRIED ______DIVORCED (*Please provide custody papers if applicable)

PLEASE GIVE INSURANCE CARD TO RECEPTIONIST

EMERGENCY CONTACT INFORMATION

NAME ____ PHONE #____)____-______

RELATIONSHIP TO PATIENT (**Someone other than mom or dad**) ___________________________________

Who referred you to our office? ____

RELEASE OF INFORMATION ASSIGNMENT OF BENEFITS ACKNOWLEDGEMENT OF TREATMENT

COPAYS & DEDUCTIBLES ARE YOUR CONTRACT WITH YOUR INSURANCE COMPANY. IF YOU DO NOT PAY IT, YOU ARE BREACHING YOUR CONTRACT. COLLECTING COPAYS & DEDUCTIBLES ARE OUR CONTRACT WITH YOUR INSURANCE COMPANY. IF WE DO NOT COLLECT THEM, WE ARE BREACHING OUR CONTRACT. COPAYS ARE PAID AT THE TIME OF SERVICE. WE REQUEST THAT DEDUCTIBLES ARE PAID IN A TIMELY MANNER.
Notice to Consumers : Medical doctors are licensed and regulated by the Medical Board of California (800) 633 – 2322 www.mbc.ca.gov

AUTHORIZATION: I hereby authorize the physician above to furnish information to insurance carriers concerning this illness/accident and I Hereby assign to the doctor all payments for medical services rendered. I authorize Dr. Jeong ok Lee and such physicians, Associates, assistants and other personnel for treatment of any illnesses/accidents. I understand that I am financially responsible for al charges whether or not covered by insurance. I understand that Dr. Jeong-ok Lee and associates are licensed and regulated by Medical Board of California.

X____ RESPONSIBLE PARTY SIGNATURE ____/____/____

PLEASE SIGN HERE TODAY'S DATE

New Patient Medical History Form

Child's Name: ____________________ **Date of Birth:** ___/___/___ **Today's Date:** ___/___/___ **Sex:** ___

Birth History

Length of pregnancy: ______ weeks ______ days

or, □ term □ preterm

Birth Weight (kg/lb): __________ Length (cm/in):__________

□ Vaginal delivery □ C-section □ breech □ twin

Complications or problems in newborn period:

□ breathing problem □ jaundice

□ feeding problem □ infection (______________)

□ NICU stay (reason:______________________)

□ other: ______________________

Complications or problems during pregnancy:

____

Medications taken during pregnancy:

____

Surgery History (please include year or age)

□ No history of surgery or procedure

1. ______________________________
2. ______________________________
3. ______________________________

Hospitalization (please include year or age)

□ No history of hospitalization

1. ______________________________
2. ______________________________
3. ______________________________

Current Medications

Name of medication	Dosage and Frequency	Reason for medication

Allergies

Please list the name and reaction to each allergen

□ Medication: ______________________

□ Food: ______________________

□ Insects: ______________________

□ History of severe allergic reaction: ______________________

Development History

Sat alone at age ____________

Walked by self at age ____________

First tooth at age ____________

Spoke 2-word sentences at age ____________

Toilet trained at age ____________

Social History

Patient lives with (list all adults and children):

□ Mother □ Father □ Grandmother □ Grandfather

□ Sisters (how many?_______) □ Brothers (how many?_______)

□ Other:

Are parents: □ married □ divorced

(if divorced, □ single custody □ double custody)

Patient lives with:

□ biological parent(s) □ adoptive family □ foster family

Family smoking: □ no □ yes

(if yes, □ inside the house □ outside the house)

Pets: □ no □ yes (what kind?______________________)

Lives in: □ house □ apartment □ built prior to 1980

Language: □ English □ Spanish □ Korean □ other:____________

Medical History (Please check all past and current problems)

□ Asthma

□ Eczema

□ Chicken pox

□ Pneumonia

□ Frequent ear infections

□ Heart murmur or heart problem

□ Kidney or bladder infection

□ Seizure or other neurological problem

□ Problems with hearing or ears

□ Problems with vision or eyes

□ Anemia or bleeding problem

□ Thyroid problem

□ Developmental problem

□ Autism

□ Congenital or genetic problem

□ Cancer

□ HIV or other STD's

□ ADHD/depression/anxiety

□ History of serious injuries/trauma

□ History of bone fracture

□ History of family violence

□ History of drug abuse

□ Any other medical problems:

____

Family Medical History

Please list all known medical problems in family members, including: Hypertension, diabetes, high cholesterol, tuberculosis infection, heart problems, stroke, cancer, genetic problems, thyroid problem, asthma, liver disease, kidney disease, hearing problem, seizure disorder, mental illness/depression, anemia or bleeding problem, and others.

Father: □ healthy □ deceased □ ______________________

Mother: □ healthy □ deceased □ ______________________

Paternal grandfather: □ healthy □ deceased □ ______________

Paternal grandmother: □ healthy □ deceased □ ______________

Maternal grandfather: □ healthy □ deceased □ ______________

Maternal grandmother: □ healthy □ deceased □ ______________

Uncle: □ healthy □ deceased □ ______________________

Aunt: □ healthy □ deceased □ ______________________

Sibling 1 (age____): □ healthy □ deceased □ ______________

Sibling 2 (age____): □ healthy □ deceased □ ______________

Sibling 3 (age____): □ healthy □ deceased □ ______________

Sibling 4 (age____): □ healthy □ deceased □ ______________

JEONG OK LEE, MD

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Walk-In Policy
I understand that the only walk-ins that the office will see are "sick patient walk-ins" only. Well-check exams, immunizations, or other walk-ins will not be seen. Doctor will only check the patient for 1 Chief Complaint. I understand that the check-up visit with the patient will be very brief (shorter than usual doctor's check-up) but the wait time will be longer. After 3 walk-ins, a patient's account may be terminated.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_______________________________ _______________ ________________________________
Patient Signature Date Physician Signature

Print Patient's Name :_____________________________ Date of Birth : __________________________

Jeong Ok Lee, MD. 1716 W. Medical Center Drive, Anaheim, CA 92801

Privacy Officer: Office Manager, 714-635-0600

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: ______________________________ Date: ______________________________________

Print Name: __________________________ Telephone: __________________________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____

____

Date of Birth: ____/____/________ ____