SAMUEL D. VAN KIRK, M.D. 2139 AIRPARK DRIVE; REDDING, CA 96001
OBSTETRICS & GYNECOLOGY TEL: (530) 247-0270; FAX: (530) 247-0271

Patient Demographics - ANNUALLY UPDATED FOR ALL PATIENTS

In order to serve you properly, we will need the following information. All information will be strictly confidential. After completing this form, please provide your current insurance card and your driver's license to the receptionist to photocopy.

Social Security Number:_____		Are you currently employed?_____
		Employer:_____
First Name:_____	Date of Birth:_____	Job Title:_____
Middle or Nickname:_____	Marital Status:_____	Employer's Address:_____
Last Name:_____		_____
Address:_____	Primary Care Physician:	Home Phone:_____
_____	_____	Cell Phone:_____
	What is your ethnicity?	Work Phone:_____
Whom shall we thank for referring you?	_____	Preferred Phone: _____
_____		Fax: _____
	SS#	E-mail:_____

First Insurance:_____ Group #:_____ ID#_____ Co-pay:___

Are you the subscriber?____ If no, please provide the subscriber's following information:

Name:_____ Date of Birth:_____ Employer:_____
Address:_____ City:_____ Home Phone:_____
_____ State:_____ Work Phone:_____

Second Insurance:_____ Group #:_____ ID#_____ Co-pay:___

Are you the subscriber?____ If no, please provide the subscriber's following information:

Name:_____ Date of Birth:_____ Employer:_____
Address:_____ City:_____ Home Phone:_____
_____ State:_____ Work Phone:_____

Spouse/Emergency Contact Information:
First Name:_____ Relationship:_____ Home Phone:_____
Last Name:_____ Work Phone:_____

Assignment of Benefits: Financial Agreement

I hereby give lifetime authorization for payment of insurance or Medicare benefits to be directly to Dr. Van Kirk, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. A service charge of 1% per month (18% per year), but in no event more than the maximum rate permissible under state law, will be charged on the unpaid balance on all accounts not paid within 30 days of the treatment date. All other payment options will need authorization prior to treatment from the business office. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all protected health information for the purposes of treatment, payment and health care operations. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient, Parent, or Guardian Signature: _____ Date: _____

www.samvankirk.com

SAMUEL D. VAN KIRK, M.D. 2139 AIRPARK DRIVE; REDDING, CA 96001
OBSTETRICS & GYNECOLOGY TEL: (530) 247-0270; FAX: (530) 247-0271

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.

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

SAMUEL D. VAN KIRK, M.D. 2139 AIRPARK DRIVE; REDDING, CA 96001
OBSTETRICS & GYNECOLOGY TEL: (530) 247-0270; FAX: (530) 247-0271

Gynecology Information: *All information will be strictly confidential.*

Pregnancy History:

How many times have you been pregnant? _____
How many times have you given birth? _____
Any C-sections? _____
How many miscarriages/abortions? _____
Date of last menstrual period: _____
Date of last Pap smear: _____
Date of last colonoscopy:_____
Date of last mammogram: _____
__Y __ N Are you preventing pregnancy?
If yes, how: _____
__Y __ N Have you had a tubal ligation?
If yes, when: _____
__Y __ N Have you had a Hysterectomy?
If yes, when and type: _____
__Y __ N Menopause? When? _____

Previous Surgical Procedures:

List previous surgeries and hospitalizations:_____

_____
_____
_____
_____

Social History:

__Y __ N Do you smoke? If you smoke:
_____ Packs/day?
__Y __ N Alcohol: 2 drinks or less/day
__Y __ N Alcohol: 3 or more drinks/day
__Y __ N Sexually Active?

Current Symptoms:

__Y __ N Do you have current concerns? If yes, explain:
_____
_____
_____
_____

Please describe your symptoms:_____
_____
_____
_____
_____
_____

Medications:

Current Medications and Dosages:_____
_____
_____
_____
Preferred Pharmacy (Name & location):_____
_____
List any allergies to medications:_____
_____

Family History:

Do you have a family history of any of the following:
__Y __ N Breast Cancer?
__Y __ N Ovarian Cancer?
__Y __ N Colon Cancer?
__Y __ N Diabetes?

SAMUEL D. VAN KIRK, M.D. 2139 AIRPARK DRIVE; REDDING, CA 96001
OBSTETRICS & GYNECOLOGY TEL: (530) 247-0270; FAX: (530) 247-0271

Authorization to Disclose Health Information

Under the Patient Privacy Act, the use and disclosure of a patient's health information is limited to strictly defined situations. These are explained in our NOTICE OF PRIVACY PRACTICES. This means that our office cannot release any information to ANYONE other than the patient (even spouses), except under certain defined situations, or unless we have the patient's written permission. Please complete this form, to indicate if you would like us to be able to speak to your family members regarding your health care.

It is our general office policy to notify patients by e-mail (for patients using secure messaging) or postal mail of all normal lab and test results and of some abnormal results (such as increased cholesterol, abnormal thyroid tests and vascular calcifications on mammograms). For most abnormal results, for lab problems (such as an inadequate specimen) and for results that necessitate further testing, our office will attempt to notify you by phone***. If you do not hear from our office by two weeks after tests are performed, please contact us.*** Many patients would like to be notified by answering machine or voicemail. Unfortunately, we cannot guarantee that such information will not be inadvertently set to, or overheard by, other individuals. Taking this into consideration, please complete this form, to indicate if you would like us to be able to leave machine messages regarding your test results.

[] I authorize the office of Dr. Sam Van Kirk to release any information regarding my healthcare to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

-OR-

[] I **DO NOT WISH** the office of Dr. Sam Van Kirk to release any information regarding my healthcare, except as explained in the NOTICE OF PRIVACY PRACTICES.

Patient signature: _____ Date: _____

[] I authorize the office of Dr. Sam Van Kirk to leave electronic messages regarding test results on my answering machine or voicemail.

-OR-

[] I **DO NOT WISH** the office of Dr. Sam Van Kirk to leave any messages regarding test results on my answering machine or voicemail.

Patient signature: _____ Date: _____

[] I do not use secure messaging and will use postal mail for lab results (I understand this will take longer for me to get my results).

-OR-

[] I **WILL NOTIFY** the office of Dr. Sam Van Kirk of any changes in my e-mail address to ensure that electronic communications are sent to me.

Patient signature: _____ Date: _____

Patient Name:_____ Date:_____

www.samvankirk.com