

# 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: office@mygastrodocs.com

## 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  
Brock Building, Suite 3005  
Elk Grove Village, IL 60007

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

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**Mary G. Kane, M.D.**  
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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** \_\_\_\_\_

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**Arlington Heights, IL 60005**

**Patient name:** \_\_\_\_\_

**PERSONAL HISTORY**

Marital Status \_\_\_\_\_ No. of children \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_  
If no, have you & when did you stop? \_\_\_\_\_

Occupation \_\_\_\_\_  
Do you consume alcohol? \_\_\_\_\_  
If yes, how much? \_\_\_\_\_

**FAMILY HISTORY**

**Mother:** Living or Deceased  
Illnesses: \_\_\_\_\_

**Father:** Living or Deceased  
Illnesses: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Age at death: \_\_\_\_\_

Age at death: \_\_\_\_\_

**Brothers:**  
Illnesses: \_\_\_\_\_

**Sisters:**  
Illnesses: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Age at death: \_\_\_\_\_

Age at death: \_\_\_\_\_

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

<u>Yes</u>	<u>No</u>	<u>Relation &amp; Age</u>
[ ]	[ ]	Ulcers _____
[ ]	[ ]	Pancreatitis _____
[ ]	[ ]	Gallstones _____
[ ]	[ ]	Hepatitis _____
[ ]	[ ]	Cirrhosis _____
[ ]	[ ]	Crohn's disease _____
[ ]	[ ]	Ulcerative Colitis _____
[ ]	[ ]	Polyps _____

<u>Cancer of the:</u>		
<u>Yes</u>	<u>No</u>	<u>Relation &amp; Age</u>
[ ]	[ ]	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?

<u>Yes</u>	<u>No</u>	<u>Explain</u>
[ ]	[ ]	Eyes _____
[ ]	[ ]	Ears _____
[ ]	[ ]	Nose _____
[ ]	[ ]	Chest/lungs _____
[ ]	[ ]	Heart _____
[ ]	[ ]	Weight loss/fever _____

<u>Yes</u>	<u>No</u>	<u>Explain</u>
[ ]	[ ]	Arms & legs _____
[ ]	[ ]	Back _____
[ ]	[ ]	Vaginal bleeding _____
[ ]	[ ]	Urination _____
[ ]	[ ]	Headaches/seizures _____
[ ]	[ ]	Anxiety/depression _____

**Patient name:** \_\_\_\_\_

**MEDICAL BACKGROUND**

**PAST MEDICAL HISTORY**

Allergies & Reactions: \_\_\_\_\_

Operations (type and year): \_\_\_\_\_

Hospitalizations (diagnosis and year): \_\_\_\_\_

Other medical problems (type and year): \_\_\_\_\_

**HAVE YOU EVER HAD:**

<u>Yes</u>	<u>No</u>	
[ ]	[ ]	Ulcers
[ ]	[ ]	Pancreatitis
[ ]	[ ]	Hepatitis
[ ]	[ ]	Cirrhosis
[ ]	[ ]	Crohn's disease
[ ]	[ ]	Ulcerative colitis

**CANCER OF THE:**

<u>Yes</u>	<u>No</u>	
[ ]	[ ]	Esophagus
[ ]	[ ]	Stomach
[ ]	[ ]	Colon
[ ]	[ ]	Liver
[ ]	[ ]	Pancreas
[ ]	[ ]	Breast
[ ]	[ ]	Ovarian
[ ]	[ ]	Uterine
[ ]	[ ]	Other: _____

**VACCINATIONS**

(date if taken):

_____	Oral Polio
_____	Tetanus
_____	Pneumonia
_____	Flu
_____	Hepatitis
_____	TB

**PREVENTIVE HEALTH CARE**

<u>Date</u>	<u>Results</u>
_____	Rectal exam _____
_____	Colonoscopy _____
_____	Stool for blood test _____

No. of children: \_\_\_\_\_

**GYNECOLOGIC**

No. of pregnancies: \_\_\_\_\_ Living: \_\_\_\_\_ Deceased: \_\_\_\_\_ Abortions: \_\_\_\_\_

Form of birth control used: \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

Most recent:

<u>Date</u>	<u>Results</u>	<u>Date</u>	<u>Results</u>
_____	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: \_\_\_\_\_

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