Jai-Hyon Rho M.D. Ph.D.
630 South Raymond Ave Suite 340
Pasadena, CA 91105
Phone: (626)793-2014 Fax(626)793-6576

Date: _____

Name: _____ **DOB:** _____

Referring Physician: _____

Primary Care Physician: _____

Chief Complaint: What is the problem that you are seeking help for?

_____

_____

When did the problem begin? _____

How did the problem begin? _____

Please describe your symptoms in your own words: Please include the location, severity, duration, what makes your symptoms better, and what makes your symptoms worse:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had any prior medical evaluation? Dates if known:

EEG (brain wave) _____ _____

CT Scan:_____ _____

MRI Scans:_____ _____

Spinal Taps: _____ _____

Angiogram: _____ _____

Carotid Duplex: _____ _____

EMG & Nerve Conduction Studies _____ _____

Others _____ _____

Do you take any vitamins or anti-oxidants: If yes, list below:

_____

_____

_____

Family History

Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Sons	_____	_____	_____	_____	_____
Daughter	_____	_____	_____	_____	_____

Social History/Habits/Life Styles

Place of birth: _____

Have you ever served in the military (Y, N) If yes, what branch? _____

Hand used for writing/eating Right or Left

Highest level of Education completed _____

Marital Status: Single - Married - Domestic Partnership - Divorced - Widow(er)

Height _____ Weight _____

Do you smoke? (Y, N) If yes, how much? _____ Pack(s) per day

Do you drink alcoholic beverages? (Y,N)

If yes: what do you drink? How much?

_____ _____

_____ _____

Do you drink coffee, tea, and/or carbonated beverages? (Y,N)

If yes, how many cups? Coffee: Tea: Carbonated beverages:

_____ _____ _____

Do you exercise regularly? (Y, N) If yes, what exercise and how often?

_____

Please describe your style of stress coping/management:

_____

_____

Other current medical Conditions & Past medical history:

High blood pressure/low blood pressure _____

Heart disease? If yes what kind? _____

Diabetes: Yes or No _____

Lung disease? Yes or No _____

Stomach, Intestinal, Liver disease If yes, what kind _____

Kidney disease? Yes or No _____

Arthritis? Yes or No _____ Rheumatoid / Osteoarthritis _____

History of cancer? Yes or No What kind? _____

Past Surgical History

Surgery	Illness:	Date:

Medication Allergy

List of Current Medications:

Name:	Dose:	How many times a day?

Review of Systems: Please circle as many as applicable to you

Consititutional: fever, fatigue, night sweats, weight gain/loss

Neuro/Psych headache, dizziness, altered vision, passing out, memory problems, gait disturbance, weakness, numbness, mental illness, personality change, depression

HEENT: vision change, hearing loss, ringing, dizziness, sinusitis

Respiratory/Cardiovascular: cough, wheezing, shortness of breath, chest pain, palipitation, irregular heart beats, leg pain, leg swelling

Gastrointestinal: stomach pain, nausea, vomiting, diarrhea, constipation, jaundice

Genitourinary: urinary frequency, burning, blood in urine, erectile dysfunction

Gynecology: vaginal discharges, infection, menstrual difficulties

Endocrine: cold/heat intolerance, polyuria, polydipsia

Musculoskeletal: arthritis, joint pain & swelling, weakness

Dermatology: itching, rash, growth

Hematology: anemia, easily bruised, bleeding tendency, blood clots

Immunology: lupus, fibromyalgia, food or environmental allergy

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Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured's Name_____
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER

Company Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

SPOUSE

Name_____
Last Name First Name Initial

Birthdate_____ Social Security #_____

Employer Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

PATIENT INSURANCE INFORMATION

Please ✓ any and all insurance coverage you or your spouse has applicable in this case.

☐ MEDICARE ☐ BLUE SHIELD ☐ AUTO ACCIDENT
☐ MEDICAID ☐ MAJOR MEDICAL ☐ UNION PLAN
☐ BLUE CROSS ☐ WORKER'S COMPENSATION ☐ OTHER

BCBS I.D. # _____

MEDICARE/MEDICAID I.D. # _____

MAJOR MEDICAL OR AUTO INSURANCE Date of accident_____

Insurance Company Name_____ Adjuster_____

Address/Phone_____ Claim #_____

Policy #_____ Effective Date_____

SPOUSE CO-INSURANCE INFORMATION

MAJOR MEDICAL ONLY
Insurance Company Name_____

Address/Phone_____

Policy #_____ Effective Date_____

MEDICAL AND LEGAL INFORMATION

Referred by_____

Present Complaint _____

Known Medical Problems_____

_____

Attorney_____

Address_____

_____

Phone_____

Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____

Person to contact in emergency (Name and Phone #)_____

PATIENT AGREEMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have Insurance coverage with_____
Name of Insurance Company

and assign directly to Dr._____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Financial Responsibility

Dear Patient,

The Information I have supplied to the office, including all personal and insurance information is current to date. I understand if my insurance should deny coverage for any reason, I am responsible for the full payment to the physician. The following are charges which are NOT covered by you medical insurance.

- "No Show" appointments – Under this policy, the patient will be charged a $10.00 fee for every missed office visit,or a $20.00 fee for every missed new patient/ physical/ nerve conduction study.
- A "No Show"is defined as any patient who misses a scheduled appointment without prior authorization, cancels an appointment with less than 3 hours notice, or arrives ½ hour late.
- Charge for Form Completion – Under this policy, the patient will be charged a minimum $20.00 for all forms brought into the office for completionby the physican and or staff.

I also understand my physician's office charges for services NOT covered by my insurance.
Please Initial Both:

_____ $10.00 – $20.00 for all "No Show" appointments.
_____ A minimum of $20.00 for all form completion.

I have read the above and understand my financial responsibility, and hereby affix my signature in acknowledge of the understanding.

Patient's Signature: _____
Patient's Name: _____
Date:_____

Thank You,

Jal Hyon Rho, M.D. P.h.D.
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Patient Consent Form (Consent For Treatment)

Jai Hyon Rho, M.D. P.h.D.
630 South Raymond Ave Suite 340
Pasadena, CA 91105
Phone: (626) 793-2014 Fax: (626) 793-6576

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 assessments and physician certification.**

I have been informed by you of your Notice Of Privacy Practices containing description of the uses and disclosures of my health information. I have given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above 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 if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

Patient's Signature: _____
Patient's Name: _____
Date: _____

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Consent For Medical Files/ Images

I hereby authorize Jai-Hyon Rho, M.D. to keep electronic records for the purpose of providing medical care, including the use of electronic images and video tapes as appropriate. There will be no commercial use of these files or images.

By signing below, indicates you have read and understand the purpose of medical files/ medical images.

Patient Name:_____

Signature:_____

Date Signed:_____

Notice Of Privacy Practices Acknowledgement

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I have received, read and understand under 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 this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

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Date: _____