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Mira Kaga, MD
Board Certified
Internal & Aesthetic Medicine

Internal Medicine Registration Form

Patient Information

Last Name	First Name

Prefix	Is This Your Legal Name?	Marital Status
☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	☐ Yes ☐ No If not, what is your legal name?	☐ Single ☐ Married ☐ Divorced ☐ Widowed
Sex	Age	Date of Birth
☐ Male ☐ Female		/ /

Home Phone	Cell Phone

How Did You Hear About Us (Please Check One Box)

☐ Doctor ☐ Insurance Plan ☐ Hospital ☐ Friend/Family ☐ Close To Work/ Home

☐ Other_____ ☐ Yellow Pages ☐ Instagram ☐ Facebook ☐ Google Search

Other Family Members Seen Here/Friends or Referred By:

Email Address

@ .com

Home Address

Street	City
State	Zip

Insurance Information (Please give your insurance card to the receptionist)

Person Responsible for Bill	Date of Birth / /	Address (If Different)
Home Phone		Is This Person a Patient Here ☐ Yes ☐ No
Occupation	Employer	Employer Phone

Employer Address

Street	City
State	Zip

Is This Patient Covered By Insurance ☐ Yes ☐ No	Group #	Policy #

Co-payment $	Patients Relationship To Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact

Name of Local Friend Or Relative (not living at same address)	Relationship to Patient
Home Phone	Work Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Kaga Institute to release any information required to process my claims.

_____ _____/_____/_____

Patient/Guardian Signature | Today's Date

Allergies To Medications ☐No Allergies

Drug Name	Allergic Reaction	Date of Last Reaction
Drug Name	Allergic Reaction	Date of Last Reaction

List Your Prescribed Drugs and Over-The-Counter Drugs, Such As Vitamins ☐No Prescribed Drugs

Drug Name	Strength	Frequency Taken
Drug Name	Strength	Frequency Taken
Drug Name	Strength	Frequency Taken
Drug Name	Strength	Frequency Taken
Birth Control		

Pharmacy Information

Pharmacy Name	Phone
Street	City
State	Zip
Do you want long-term scripts sent to mail-order pharmacy?	☐Express Scripts ☐OptumRX ☐Other If Other, please provide name:

Medical History

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Childhood Illnesses		☐No Childhood Illnesses
☐Measles	☐Mumps	☐Rubella
☐Chickenpox	☐Rheumatic Fever	☐Polio
☐Tetanus Date / /	☐Pneumonia Date / /	☐Hepatitis Date / /
☐Chickenpox/Shingles Date / /	☐Influenza Date / /	☐MMR Measles, Mumps, Rubella Date / /

Previous or Referring Doctor	Date Of Last Physical Exam / /	Date Of Last Blood Work / /

List any Medical Problems That Other Doctors Have Diagnosed	☐ No Medical Problems
Date / /	Problem
Date / /	Problem
Date / /	Problem
Date / /	Problem

Surgeries		☐ No Surgeries
Year	Reason	Hospital
Year	Reason	Hospital

Other Hospitalizations		☐ No Hospitalizations
Year	Reason	Hospital
Year	Reason	Hospital

Family Health History

Father	
Age	Significant Health Problems

Mother	
Age	Significant Health Problems

Sibling	
☐ Male ☐ Female	Significant Health Problems
☐ Male ☐ Female	Significant Health Problems
☐ Male ☐ Female	Significant Health Problems

Children	
☐ Male ☐ Female	Significant Health Problems
☐ Male ☐ Female	Significant Health Problems
☐ Male ☐ Female	Significant Health Problems

Grandmother (Maternal)	
Age	Significant Health Problems

Grandfather (Maternal)	
Age	Significant Health Problems

Grandmother (Paternal)	
Age	Significant Health Problems

Grandfather (Paternal)	
Age	Significant Health Problems

Any other family members with heart attack, stroke, or cancer?

Social History

Exercise

☐ Sedentary (no exercise)	☐ Mild Exercise (ie, climb stairs, walk 3 blocks, golf)
☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Alcohol

Do you drink alcohol	☐ Yes ☐ No	If Yes, What Kind?	How Many Drinks Per Week?
Are you concerned about the amount you drink?	☐ Yes ☐ No		
Have you considered stopping?	☐ Yes ☐ No		
Have you ever experienced blackouts?	☐ Yes ☐ No		
Do you drive after drinking?	☐ Yes ☐ No		

Tobacco

Do you use tobacco now? ☐ Yes ☐ No	Did you use tobacco ever? ☐ No ☐ Yes Started_____Quit_____Packs_____		
Cigarettes - packs/day	Chew - #/day	Pipe - #/day	Cigars - #/day

Drugs

Do you currently use recreational or street drugs?	☐ Yes ☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes ☐ No

Sex

Are you sexually active?	☐ Yes ☐ No
If yes, are you trying for a pregnancy?	☐ Yes ☐ No
If not trying for a pregnancy list contraceptive or barrier method used:	
Any discomfort with intercourse?	☐ Yes ☐ No
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes ☐ No

Personal Safety Assessment

Do you live alone?	☐ Yes ☐ No
Do you have frequent falls?	☐ Yes ☐ No
Do you have vision or hearing loss?	☐ Yes ☐ No
Do you have an Advance Directive or Living Will	☐ Yes ☐ No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes ☐ No

Mental Health Assessment

Is stress a major problem for you?	☐ Yes ☐ No
Do you feel depressed?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No
Have you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No

Preventative Care

Have you ever had a blood transfusion?	☐ Yes ☐ No	Date / /
Have you had a colonoscopy?	☐ Yes ☐ No	Date / /
Have you had an endoscopy?	☐ Yes ☐ No	Date / /
Have you had an EKG?	☐ Yes ☐ No	Date / /
Have you had a stress test?	☐ Yes ☐ No	Date / /
Have you had a Dexa scan (bone density)?	☐ Yes ☐ No	Date / /
Have you had a mammogram?	☐ Yes ☐ No	Date / /
Have you had a pap smear or prostate exam?	☐ Yes ☐ No	Date / /
Have you had an eye exam?	☐ Yes ☐ No	Date / /
Have you had a hearing exam?	☐ Yes ☐ No	Date / /

Women Only (Part 1)

Age at onset of menstruation	Date of last menstruation	How many days between periods?	Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No

Number of pregnancies	Number of live births

Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No

Women Only (Part 2)

Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No

Men Only

Do you usually get up to urinate during the night?	☐ Yes ☐ No	If yes, # of times
Do you feel pain or burning with urination?		☐ Yes ☐ No
Any blood in your urine?		☐ Yes ☐ No
Do you feel burning discharge from penis?		☐ Yes ☐ No
Has the force of your urination decreased?		☐ Yes ☐ No
Do you have any problems emptying your bladder completely?		☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?		☐ Yes ☐ No
Any difficulty with erection or ejaculation?		☐ Yes ☐ No
Any testicle pain or swelling?		☐ Yes ☐ No

Other Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. ☐ No Symptoms

☐ Skin Explain:	☐ Chest/Heart Explain:	☐ Head/Neck Explain:
☐ Back Explain:	☐ Ears Explain:	☐ Intestinal Explain:
☐ Nose Explain:	☐ Bladder Explain:	☐ Throat Explain:
☐ Bowel Explain:	☐ Lungs Explain:	☐ Circulation Explain:

Recent Changes In ☐ No Changes

☐ Weight	☐ Energy Level	☐ Ability To Sleep

☐ Other Pain/Discomfort
Explain:

Is there anything else you would like to discuss with the doctor today?

_____ _____ / _____ / _____

Patient Signature Today's Date

HIPAA Privacy Authorization Form

Authorization for use or disclosure of protected health information

(Required by the health insurance portability and accountability act - 45 CFR parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named

2. Authorization for release of PHI covering the period of health care (check one)

☐ Date	☐ All past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):

☐ My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDs, and treatment of alcohol/drug abuse).	☐ My complete health record with the exception of the following information (check as appropriate): ☐ Mental Health ☐ Communicable Diseases ☐ Alcohol/Drug Abuse Treatment ☐ Other (Please Specify):

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name	Relationship
Name	Relationship
Name	Relationship

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or

_____

(date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____/_____/_____

Patient Signature Today's Date