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**K. Christopher Oh, M.D.**

**3633 West Lake Avenue, Ste 410**

**Glenview IL 60026**

**Patient Information (PLEASE MAKE SURE TO READ OUR POLICY ON THE NEXT PAGE)**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.:\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Include Unit #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday:\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_

Language: ( ) English, ( ) Korean, ( ) Spanish, ( ) Others: \_\_\_\_\_\_\_\_

Marital Status: ( ) Single, ( ) Married, ( ) Divorced, ( ) Separated, ( ) Widowed

Ethnicity: ( ) White, ( ) Asian, ( ) Hispanic, ( ) African American, ( ) American Indian, ( ) Others

**Clinical Information**

**Please list all current medical problems**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all past surgeries**:

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**Allergies to medications?**

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**Current Medications (please include dose and frequency**):

Name of medication Dose How many times per day do you take it?

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**Pharmacy Information**

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

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PAYMENTS & INSURANCE:

* YOU ARE EXPECTED TO PAY YOUR DEDUCTIBLES, COINSURANCES AND COPAYMENTS.
* PATIENTS WITH AN OUTSTANDING BALANCE 60 DAYS OF MORE OVERDUE MUST MAKE ARRANGEMENTS FOR PAYMENT PRIOR TO SCHEDULING APPOINTMENTS.
* WE DO NOT RETROACTIVELY BILL FOR CLAIMS USING INSURANCE THAT WAS NOT AVAILABLE AT TIME OF SERVICE.
* IF WE HAVE NOT RECEIVED PAYMENT FROM YOUR INSURANCE COMPANY WITHIN 45 DAYS OF THE DATE OF SERVICE, YOU WILL BE EXPECTED TO PAY THE BALANCE IN FULL. YOU ARE RESPONSIBLE FOR PAYMENT OF ALL CHARGES WHETHER BY YOU OR BY YOUR INSURANCE CARRIER.
* IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT OUR OFFICE HAS UP TO DATE ADDRESS AND INSURANCE INFORMATION.

PHONE CALLS, PRESCRIPTION REFILLS & URGENT CARE:

* PHONE CALLS, MESSAGES AND PRESCRIPTION REFILL REQUESTS WILL BE ADDRESSED WITHIN 24 HOURS.
* YOU WILL NEED OFFICE VISIT AND COMPREHENSIVE BLOOD TEST WITHIN A YEAR TO HAVE YOUR PRESCRIPTION REFILLED.
* IF YOU CALL WITH URGENT SYMPTOMS OR CANNOT BE EVALUATED IN OUR OFFICE IMMEDIATELY, WE RESERVE THE RIGHT TO DIRECT YOU THE NEAREST EMERGENCY ROOM OR URGENT CARE.
* FOR MEDICAL MATTERS OF MODERATE COMPLEXITY, WE REQUIRE THAT YOU MAKE AN APPOINTMENT FOR OFFICE VISIT INSTEAD OF A PHONE CALL.

REFERRALS, PRIOR AUTHORIZATIONS & APPOINTMENTS:

* OFFICE VISIT IS REQUIRED FOR EVALUATION FOR REFERRALS AND ORDERS FOR TESTS. WE WILL MAKE REFERRALS AND ORDERS FOR TESTS THAT ARE MEDICALLY NECESSARY
* IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, WE ASK THAT YOU LET US KNOW 24 HOURS IN ADVANCE. AFTER 3 NO-SHOWS YOU CAN NO LONGER MAKE AN APPT IN OUR OFFICE

MEDICAL FORMS:

* CERTAIN FORMS (INCLUDING PREOP, FMLA, SHORT-TERM DISABILITY, SICK LEAVE, RETURN TO WORK, SCHOOL OR WORK PHYSICALS) REQUIRE AN OFFICE VISIT. IF YOU HAD RECENTLY BEEN TO THE OFFICE, YOU MAY STILL BE REQUIRED TO COME IN FOR A SEPARATE VISIT IF THE PRIOR VISIT WAS NOT SPECIFICALLY FOR THE MEDICAL ISSUES ON THE FORM.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY. I HEAD BY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MEDICARE AND/OR INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIANS FOR SERVICES. IT IS UNDERSTOOD THAT THIS AUTHORIZATION DOES NOT RELIEVE ME FROM THE RESPONSIBILITY FOR CHARGES AND ANY BALANCE NOT PAID BY MY INSURANCE COMPANY, WHICH SHALL BE PAID BY ME UPON RECEIPT OF BILLING.

(PLEASE READ CAREFULLY BEFORE SIGNING)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_