

732.719.2001

info@drkaga.com

732.719.2002

58 North Main Street
Marlboro, NJ 07746



The Kaga Institute
OF MEDICINE & AESTHETICS

Mira Kaga, MD

Board Certified
Internal & Aesthetic Medicine

Internal Medicine Registration Form

Patient Information				
Last Name		First Name		
Prefix <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Is This Your Legal Name? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what is your legal name?		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Age		Date of Birth / /
Home Phone		Cell Phone		
How Did You Hear About Us (Please Check One Box)				
<input type="checkbox"/> Doctor	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Friend/Family	<input type="checkbox"/> Close To Work/ Home
<input type="checkbox"/> Other _____	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Instagram	<input type="checkbox"/> Facebook	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation		Employer		Employer Phone
Employer Address				
Street		City		
State		Zip		
Is This Patient Covered By Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		Group #		Policy #
Co-payment \$		Patients Relationship To Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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? <input type="checkbox"/> Express Scripts <input type="checkbox"/> OptumRX <input type="checkbox"/> 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

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
<input type="checkbox"/> Tetanus Date / /	<input type="checkbox"/> Pneumonia Date / /	<input type="checkbox"/> Hepatitis Date / /
<input type="checkbox"/> Chickenpox/Shingles Date / /	<input type="checkbox"/> Influenza Date / /	<input type="checkbox"/> 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			<input type="checkbox"/> No Medical Problems
Date	/	/	Problem
Date	/	/	Problem
Date	/	/	Problem
Date	/	/	Problem

Surgeries			<input type="checkbox"/> No Surgeries
Year	Reason	Hospital	
Year	Reason	Hospital	

Other Hospitalizations			<input type="checkbox"/> No Hospitalizations
Year	Reason	Hospital	
Year	Reason	Hospital	

Family Health History

Father

Age	Significant Health Problems
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Mother

Age	Significant Health Problems
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Sibling

<input type="checkbox"/> Male <input type="checkbox"/> Female	Significant Health Problems
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<input type="checkbox"/> Male <input type="checkbox"/> Female	Significant Health Problems
---	-----------------------------

<input type="checkbox"/> Male <input type="checkbox"/> Female	Significant Health Problems
---	-----------------------------

Children

<input type="checkbox"/> Male <input type="checkbox"/> Female	Significant Health Problems
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<input type="checkbox"/> Male <input type="checkbox"/> Female	Significant Health Problems
---	-----------------------------

<input type="checkbox"/> Male <input type="checkbox"/> 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
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Preventative Care

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had a colonoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had an endoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had an EKG?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had a stress test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had a Dexa scan (bone density)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had a mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had a pap smear or prostate exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had an eye exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	/	/
Have you had a hearing exam?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies		Number of live births	
Are you pregnant or breastfeeding?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Women Only (Part 2)

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

Men Only

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

<input type="checkbox"/> Skin Explain:	<input type="checkbox"/> Chest/Heart Explain:	<input type="checkbox"/> Head/Neck Explain:
<input type="checkbox"/> Back Explain:	<input type="checkbox"/> Ears Explain:	<input type="checkbox"/> Intestinal Explain:
<input type="checkbox"/> Nose Explain:	<input type="checkbox"/> Bladder Explain:	<input type="checkbox"/> Throat Explain:
<input type="checkbox"/> Bowel Explain:	<input type="checkbox"/> Lungs Explain:	<input type="checkbox"/> Circulation Explain:

Recent Changes In No Changes

<input type="checkbox"/> Weight	<input type="checkbox"/> Energy Level	<input type="checkbox"/> Ability To Sleep
<input type="checkbox"/> 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

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

<input type="checkbox"/> Date	<input type="checkbox"/> All past, present and future periods.
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3. I hereby authorize the release of PHI as follows (check one):

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