Robert Kearney, MD
4510 Executive Drive, Suite 103
San Diego, CA 92121
(858) 677-9352
www.KearneyMD.com

Robert Kearney, MD

PATIENT INFORMATION FORM

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier (to receive text appt confirmation): _____

DOB: _____ Age: _____ Gender: _____

Social Security Number: _____ Email Address: _____

Occupation: _____

How did you hear about our clinic?

☐ KearneyMD.com ☐ Patient Referral: _____ ☐ Dr. Referral: _____

☐ Other Website: _____ ☐ Friend: _____ ☐ Other: _____

What is the nature of your visit? _____

_____

_____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Email	☐Yes ☐No	☐Yes ☐No	☐	
☐ Text	☐Yes ☐No	☐Yes ☐No	☐	

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Section I: Surgical History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	
12. Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

Section V: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

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Section VI: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Office Policies:

Appointments:
All consultations, services and treatments are by appointment only and a credit card number must be provided to reserve your appointment. We send appointment reminders via text, email or phone calls.

Cancellations & No-Shows:
If you need to cancel or reschedule your appointment, please give at least 24 hours notice. Should you miss your appointment without calling or emailing to cancel or reschedule then you will be charged a $75 no-show fee.

Late Arrivals:
If you are more than 15 minutes late to your appointment, we may need to reschedule you. If you are more than 30 minutes late you will be charged a $75.00 no-show fee.

Refunds:
All services and treatments offered are non-refundable. We will accept any un-opened/unused products within 30 days of purchase. Aesthetic treatment results will vary patient to patient, and aside from certain touch-ups done at follow-up appointments, any additional treatments needed to achieve desired results will be priced as an additional treatment.

Children and Pets:
We love both! However, we do ask that you make childcare arrangements prior to your appointment. This ensures the safety of your children as well as a tranquil experience for you and other patients. For the health and safety of all patients, we ask that you do not bring any animals, other than service animals, into our office. Our building also has a no-pet policy.

I understand, and agree to, the above policies.

Signature: _____ **Date:** _____

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HIPAA Information and Consent Form

Patient Name:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ **Date:** _____