Takashi Yoshida, MD

2490 Hospital Drive, Suite 103, Mountain View, CA 94040 (650) 962-4640

Patient's Name: ____ **Birth Date:** ____________________ **M/F**

Last First M-D-Y

Patient's Name: ____ **Birth Date:** _______________________ **M/F**

Last First M-D-Y

Patient's Name: ____ **Birth Date:** _______________________ **M/F**

Last First M-D-Y

Address: ____

Street Apt# City State Zip Code

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Father's Name: ____ **Birth Date:** ____________________________

Last First M-D-Y

Employer: ____ **Cell Phone:** ___________________________

Address: ____ **Work Phone:** ___________________

Street City State Zip Code

Email Address: ____

Mother's Name: ____ **Birth Date:** ____________________________

Last First M-D-Y

Employer: ____ **Cell Phone:** ___________________________

Address: ____ **Work Phone:** ___________________

Street City State Zip Code

Email Address: ____

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Primary Insurance by: Mother Father

Insurance Plan: _________________________________ **ID#** _____________________________ **Group#** _____________________

Primary Insurance by: Mother Father

Insurance Plan: _________________________________ **ID#** _____________________________ **Group#** _____________________

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Emergency Contact:

Name: ____ **Phone#** ___________________________________

Address: ____

Street City State Zip Code

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I understand my signature requests for insurance payments to Takashi Yoshida, MD, Inc., and transfers release of medical information necessary to pay my child's claims. <u>I realize I am responsible for keeping my insurance and address current and up to date</u>. In the event any insurance claims are not paid, I will be responsible for the balance on the account. _______________

Initials

___________________________ ____ _________________________

Relationship to patient **Signature of parent/Guardian** **Date**

Takashi Yoshida MD, Inc. Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Takashi Yoshida, MD, Inc., we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information to contact you. For example, we may want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

If we change any details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Carmen at (650) 962-4640.

This notice goes into effect as of April 1, 2003.

Acknowledgement

I have the right to request a copy of the Takashi Yoshida MD, Inc., Notice of Privacy Practices.

Date:____________________________

Signed: ________________________________ Print Name:_____________________________

If signing as a parent or guardian, please note the name of the patient_______________________

Takashi Yoshida MD, Inc

Pediatric History Date:

Patient Name: ____________________________________ M/F Birthdate:_______________________

Hospital Born:____

Type of Delivery: Term: Labor: APGAR: Blood Type:

Birth Weight: Birth Length: Jaundice: Circumcision: Y/N

Family Members	DOB	Blood Type	Medical History	Relative Family History
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				

Feeding/Nutrition	Age	Past History: Please circle and sate if your child has had any of:	
Breast Feed		Roseola	
Formula		Measles	
Baby Food		Rubella	
Cow's Milk		Mumps	
		Chicken Pox	
Vitamins		Pertussis	
Fluoride		5th Disease	
Allergies		Pneumonia	
		Severe Diarrhea	
Milestones		Hand,Foot,Mouth Disease	
Held Head Up		Allergic Conjunctivitis	
Sat Alone		Atopic Dermatitits	
Crept/Crawled		Acute Gastroenteritis	
Walked		Urinary Tract Infection	
First Words		Acute Otitis Media	Food Poisoning
Sentences		Allergic Rhinitis	Asthma
Teeth		Febrile Seizure	Sinusitis
Toilet Trained		Allergy to Food	
		Allergy to Medication	
		Injury : Laceration	
		Fracture	
		Hospitalization	

In the event I________________________________, cannot be reached by phone to discuss my child's illness, x-ray reports, laboratory results or treatment, I hereby authorize Takashi Yoshida, MD to leave a detailed message at my home or cell phone.

Parent/Guardian Signature:_________________________________ Date:__________________