Grace H. Jeon, M.D., M.P.H., F.A.C.S.
A Professional Corporation
1245 Wilshire Blvd., Suite 907, Los Angeles, CA 90017
Phone: 213-482-4005 ~ Fax: 866-409-7981
www.GJeonMD.com

INSTRUCTIONS FOR NEW PATIENTS

This packet includes directions to the office, a notice of privacy policies and paperwork for your office appointment. Please fill out the forms in black ink (no pencil).

Please bring to your appointment:

- Completed paperwork
- Any applicable insurance cards
- Identification with photo
- A list of your medications
- Co-payment (if applicable) as cash or check

If you have not already made an appointment, please call our office at (213) 482-4005 to make an appointment.

Thank you.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses & Disclosure:

Our practice collects personal (protected) health information on you that may be used for three primary purposes:

1. **Treatment** – For example, we will keep a record of information each time we see you in or out of the office while you are under our care. This medical record is used to keep track of changes in your condition as well as remind us of your past care, treatment, allergies and other facts relevant to your overall health. This information may be passed on to other providers as part of a coordinated health care program for you.
2. **Payment** – We must report elements of your protected health information, such as specific treatments, visits, tests and surgeries along with related diagnoses to third party payers to properly determine benefits payable on your behalf for the services we render. We only report the minimum necessary information to process the claim.
3. **Health Care Operations** – In order to provide you with high-quality health care we often need to be able to use your protected health information for purposes such as pre-registering you at the hospital if you ever need to be admitted or providing your pharmacy with a prescription so that it is ready to pick up when you arrive. We may call you by name when the physician is ready to see you. We may use or disclose your protected health information if necessary to contact you with test results or remind you of your appointment. Again, we are committed to using the minimum necessary information to achieve these purposes.

In addition, we will use or disclose your protected health information under the following circumstances:

- When we receive a valid written or oral authorization from you
- If we are required by law to disclose your protected health information to others such as public health agencies

Required Disclosures:

We are required to disclose the information to you if you request it and we are required to disclose the information to the US DHHS for compliance determinations of this practice. We may disclose information about you without your authorization for the following reasons:

- When required by law, for judicial proceedings or law enforcement
- For workers compensation
- For uses and disclosures about decedents
- Uses and disclosures for cadaveric tissue donation
- To avert a serious threat to public health or safety
- Disclosures about abuse or neglect or domestic violence
- Information to the military or government if required by law

Other Disclosures:

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization by writing to us at our practice address or delivering a written revocation to us in person.

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You have a right to:

- request restrictions on the use and disclosure of your protected health information. Our practice is not obligated to accept your restrictions though. However, if we do accept the restriction it must be complied with fully on our part.

- request that you receive your health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. We will not ask for an explanation regarding the basis for the request.

- inspect and have a copy of your protected health information. If you would like a copy please request the information in writing or use a form available in our office for the request.

- request amendments to your personal information. We will not amend any information we did not create. We are not obligated to make an amendment to your protected health information but we will include your request for the amendment as part of your protected health information.

- an accounting for the prior six years (but no earlier than the effective date of this notification) for uses and disclosure for purposes other than treatment, payment and health care operations of our practice.

- a paper copy of this notification. The current version will be provided to you at your request. It may also be viewed at our website at www.GJeonMD.com.

Our Duties:

We are obligated by law to protect your privacy and we will do our utmost to fulfill that duty to you. We will abide by all the terms in this notification but we reserve the right to change the terms of this notice and the personal health information it protects. You are entitled to a copy of those changes. Copies of any revised notice will be available in the office and posted on the website www.GJeonMD.com.

We will do our very best to make certain your rights are protected and we carry out our responsibilities to you. If you have any complaint we encourage you to contact us. It is our sincere desire to preserve your privacy and fulfill our duties. We will take no retaliatory action against any person for exercising their right to the resolution of a grievance. To the contrary we encourage your comments and criticisms. If we cannot resolve the issue for you, you have the right to file a grievance and make a complaint to the US Department of Health & Human Services.

Effective Date: June 14, 2004; revised 6/30/2014

To make a complaint or ask any questions concerning this policy please contact Dr. Jeon at 213-482-4005.

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Patient Name (please print): _____

Date of Birth: _____

- I have received a copy of the Notice of Privacy Practices for Grace H. Jeon, M.D., M.P.H., F.A.C.S., A Professional Corporation.
- I understand that my medical records will be stored electronically (including signed documents) and that the original paper copies will not be saved.

_____

Signature of Patient or Representative

_____

If Representative, please print name and indicate relationship

_____

Date

Grace H. Jeon, M.D., M.P.H., F.A.C.S., A Professional Corporation

GENERAL SURGERY

PATIENT REGISTRATION FORM

NAME (LAST, FIRST, MI):	**DATE:**

PATIENT INFORMATION

DATE OF BIRTH:	SOCIAL SECURITY NUMBER
GENDER: ☐ MALE ☐ FEMALE	REFERRING DOCTOR:
HOME ADDRESS:	HOME PHONE:
	WORK PHONE:
	MOBILE PHONE OR PAGER:
E-mail address:	
MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐ HAVE PARTNER	
ARE YOU COMFORTABLE WITH ENGLISH? ☐ YES ☐ NO PREFERRED LANGUAGE:	
RACE:	ETHNICITY:
OCCUPATION, TITLE:	
EMPLOYER NAME, ADDRESS:	

EMERGENCY CONTACT INFORMATION

NAME:
PHONE:
RELATIONSHIP:

INSURANCE AND BILLING INFORMATION

(Please give your cards to the office staff for copying.)

GUARANTOR NAME:	RELATIONSHIP:
GUARANTOR ADDRESS IF DIFFERENT FROM ABOVE:	PHONE:
PRIMARY INSURANCE COMPANY NAME:	**SECONDARY INSURANCE COMPANY NAME:**

- **I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM.**
- **I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED TO THE PRACTICE OF GRACE H. JEON, MD, MPH, FACS, PROF CORP.**
- **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COPAYMENTS , DEDUCTIBLES AND NON COVERED SERVICES AS DETERMINED BY INSURANCE POLICY**

SIGNED_____**DATE**_____

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This form tells us how we may contact you regarding your Protected Health Information. Please note that, depending on the methods of contact you indicate, there may be a delay in contacting you regarding test results, re-scheduling appointments, and other matters. Thank you for your cooperation.

Please note that we are not required to agree to all requests. Please see our Notice of Privacy Practices for more information.

Patient Name (print):_____
Date of Birth:_____

Method of contact allowed (please check any/all that apply):

- ☐ **Home phone number --**personal contact
  - ○ answering machine or voicemail
  - ○ message left with family member or other person answering phone
- ☐ **Home address (regular mail)**
- ☐ **Work phone number--**personal contact
  - ○ answering machine or voice mail
  - ○ message left with person answering phone
- ☐ **Work address (regular mail)**
- ☐ **Mobile phone or pager**—personal contact
  - ○ voicemail
  - ○ message left with family member or other person answering phone
- ☐ **Other** (please specify):_____
- ☐ **Individuals with whom your Protected Health Information may be discussed** (name, relationship, contact info):
  - □ **Emergency contact listed on registration form**

_____

_____

_____

Please note any restrictions on disclosure of Protected Health Information:

_____

Signature of Patient or Legal Guardian:_____

Date:_____

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CONSENT FOR RELEASE OF MEDICATION HISTORY

OUR OFFICE HAS THE ABILITY TO ACCESS YOUR MEDICATION HISTORY ELECTRONICALLY AND TO PRESCRIBE MEDICATIONS ELECTRONICALLY

Patient Name (please correct as needed):

Date of Birth:

- By signing below, I give consent for Dr. Jeon and her office staff to access my medication history electronically.

_____ _____
Signature of Patient or Representative Date

_____

If Representative, please print name and indicate relationship

My preferred pharmacy is:

Name of pharmacy:	
Address or location:	
City, Zip code:	
Phone number:	
Fax number:	

Revised 9/2018

MEDICAL INFORMATION FORM

Grace H. Jeon, M.D., M.P.H., F.A.C.S.
General Surgery

NAME _____

DATE OF BIRTH _____AGE_____

TODAY'S DATE_____

HEIGHT _____ WEIGHT _____

SMOKING _____ PACKS PER DAY FOR _____ YEARS
ALCOHOL _____

FAMILY HISTORY (LIST SIGNIFICANT ILLNESSES)

FATHER _____
MOTHER _____
BROTHERS _____
SISTERS _____
CHILDREN _____
ANY FAMILY HISTORY OF CANCER _____
_____

DO YOU HAVE ANY DIFFICULTIES WITH YOUR…

WEIGHT GAIN/LOSS_____ ☐ NO
FEVERS_____ ☐ NO
EYES _____ ☐ NO
EARS/NOSE/MOUTH/THROAT_____ ☐ NO
GLANDS _____ ☐ NO
LUNGS _____ ☐ NO
HEART/CIRCULATION_____ ☐ NO
LIVER _____ ☐ NO
DIGESTION _____ ☐ NO
URINATION _____ ☐ NO
MUSCLES/JOINTS/NERVES_____ ☐ NO

MARK SIGNIFICANT PAST OR PRESENT PROBLEMS WITH…

☐ STROKE ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ DIABETES
☐ HEPATITIS ☐ KIDNEY FAILURE
☐ TUBERCULOSIS ☐ THYROID DISEASE
☐ CANCER ☐ ASTHMA
☐ HIV/AIDS

LIST ANY OTHER MEDICAL PROBLEMS YOU MAY HAVE:

_____

_____

LIST ALL PREVIOUS SURGERIES WITH DATES

_____
_____
_____
_____
_____
_____

LIST ALL CURRENT MEDICATIONS (OR ATTACH LIST)

_____
_____
_____
_____
_____
_____
_____
_____
_____

HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO DENTAL OR SURGICAL PROCEDURES? ☐ YES ☐ NO

MARK IF YOU ARE ALLERGIC TO …

☐ PENICILLIN ☐ SULFA ☐ CODEINE
☐ MORPHINE ☐ IODINE ☐ ADHESIVE TAPE
☐ NO KNOWN MEDICAL ALLERGIES

LIST ANY OTHER MEDICAL ALLERGIES _____
_____

HAVE YOU EVER HAD A BLOOD OR BLOOD PRODUCT TRANSFUSION? ☐ YES ☐ NO

OBSTETRIC REVIEW

NUMBER OF PREGNANCIES _____ NUMBER OF BIRTHS _____
AGE AT 1ST TERM PREGNANCY _____
WERE ANY BY CESAREAN SECTION? ☐ YES ☐ NO
WERE ANY BY VAGINAL DELIVERY? ☐ YES ☐ NO
DATE OF LAST MENSTRUAL PERIOD: _____
AGE AT ONSET OF MENSTRUATION: _____
HAVE YOU EVER TAKEN HORMONES OR CONTRACEPTIVES?
_____

OFFICE USE – DO NOT WRITE BELOW
REVIEWED _____

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Driving Directions:

1245 Wilshire Blvd, Suite 907
Los Angeles, CA 90017

(located in the Good Samaritan Hospital Medical Office building, North Tower)

Parking is available in the Good Samaritan Hospital parking garage (parking not validated).

The hospital garage is located on Shatto Street, just west of the hospital entrance (on Witmer). The office building is at the northeast corner of Wilshire and Witmer.

From the 110 Freeway-North:

- Take 110 Freeway North to 3rd Street exit (will take you over freeway)
- Left at first light - Beaudry
- Right on 6th Street from Beaudry
- Left on Witmer (Hospital is on the left and parking is on the right)
- Right on Shatto St. (parking garage entrance on the right)

From the 110 Freeway-South:

- Take the 110 Freeway South to the Wilshire Boulevard exit
- Make a right at end of ramp - this is Wilshire Boulevard
- Right on Witmer St.
- Left on Shatto St. (parking garage entrance on the right)