Victor V. Kitt, M.D.

PATIENT REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	**Marital status (circle one)** Single / Mar / Div / Wid
Address:		**Birth date:** / /	**Age:** **Gender:** ❑ M ❑ F
City:		**State:**	**Zip Code:**
P.O. box:	**Social Security No.:**	**Phone Number:** ( )	**Race/Ethnicity**
Occupation:	Employer:		Employer phone no.: ( )

Referred to our office by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family/Friend ❑ Yellow Pages ❑ Other

Email:

INSURANCE INFORMATION

Primary Insurance:		**ID Number:**
Secondary Insurance:		**ID Number:**

RESPONSIBLE PARTY

If patient is a minor use parent/guardian information here

Name:		**Relationship to patient:**
D.O.B.: / /	**Phone Number: ( )**	**SSN:**
Address:		
City:	**State:**	**Zip Code:**

PREFERRED PHARMACY

Name	
Address:	**Phone number:**
Primary Care Physician:	**Phone Number:**

IN CASE OF EMERGENCY

Name of local friend or relative :	**Relationship to patient:**	**Home/ Cell Phone no.:** ( )

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 Victor V. Kitt, M.D. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

Victor V. Kitt, MD
2701 16th St. Suite A Bakersfield, CA 93301

HIPAA Acknowledgement and Communication Form

I acknowledge that I have read and agreed to the Notice of Privacy Practices of **Victor V. Kitt, MD**.

Print Patient Name: _____ **DOB** _____

Signature of Patient: (Guardian or Authorized Representative):

_____

Date of Signature: _____ **Relationship to Patient:** _____

We value you right to privacy; therefore, we would like you to determine how to handle our telephone communications with you. We routinely call patients for the following reasons:

1. To confirm appointments

2. Test results

3. To reply to your questions and/or concerns

If we attempt to contact you and you are not available, what would you like us to do?

_____ Leave information on an answering machine/voicemail #_____

_____ Do not leave information on my answering machine/voicemail or with any member of my family

_____ Leave information in my email

Email Address_____

_____ Leave information with my family members.

I grant **Victor V. Kitt, MD** permission to discuss my care with the following:

Name: _____ Phone Number _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

Signature: _____ Date: _____

Victor V. Kitt, M.D.

Name: _____ Date of birth: _____

Reason for Visit/ Main Complaint(s):

_____

_____

_____

_____

Medical History: (i.e. diabetes, high blood pressure, etc.)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Previous Surgeries:

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Prescribed Medications:

1._____
2._____
3._____
4._____
5._____
6._____

Over the counter Medications (Vitamins, Herbs):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies (medication, food, animals):

1._____ Reaction: _____
2._____ Reaction: _____
3._____ Reaction: _____
4._____ Reaction: _____
5. _____ Reaction: _____

Family History (i.e. Cancer, Diabetes, Heart Problems, etc.):

1._____ 3._____
2._____ 4._____

Social History

- Smoker: Y___ N___; How many per day/week: _____; Exposed to Smoke: Y___ N___
- Drinker: Y___ N___: How many per day/week: _____

Job titles and duties: _____

Hobbies: _____

Animal Contact (i.e. pets): _____

VICTOR V. KITT, M.D.

2701 16th Street # A., Bakersfield, Ca. 93301
(661)322-1258 Fax (661)637-1112

EAR, NOSE, THROAT, & SINUS DISEASES
HEAD & NECK TUMOR SURGERY
BOARD CERTIFIED IN OTOLARYNGOLOGY

Patient-Physician Relationship

To our patients:

To build our best possible patient-physician relationship, please note the following issues:

1. Fill out patient information form thoroughly. Some prescription drugs and medical terms may be difficult for you. Please ask our staff or inform your physician directly.
2. Please be on time for your future appointments. If you are more than fifteen (15) minutes late for your appointment, then your appointment will be re-scheduled. If you are more than thirty (30) minutes past your appointment time, than you will be considered a no show. More than two no shows without causes may be considered as patient-physician relationship termination.
3. Questions about diagnosis, plans of tests and recommendations should be asked at your visits. Patient education and satisfaction is vitally important to us. Do not leave our office with doubts in your minds.
4. Release of medical records must be requested and the required forms should be filled out. Please follow our office policies in order to comply with the confidentiality law. There is a $25.00 fee that will have to be pre-paid before releasing any records.
5. Each insurance has its own policies. We shall observe issues such as, authorizations and co-payments strictly. Allow time for us to contact your insurance companies. All medical claims are filed directly to your insurance from our office.
6. We strive to serve you promptly. At times other patients' care, hospital emergencies or prolonged surgeries may delay your appointment time. Effort will be made to inform you in advance or reschedule your appointment to a future date.
7. **Issues pertaining to minors:**
   They must be accompanied by one parent or guardian as required by law. For the minors who have more than one set of parents, a spokesperson should be designated in relating the medical information and decision to the family members.
8. Refilling medications must be requested during our office hours. Pharmacy FAX is our other preferred method. Narcotic refills must follow strict rules of the DEA policies.
9. In cases of doubts, confidence or disputes which may threaten a good patient-physician relationship, a friendly departure may be the best policy to follow. Both patient and physician may notify each other without stating causes accordingly. Ample time lapse will be given.
10. If you are satisfied with our patient-relationship, please tell others!! If not, please tell us!!
11. It is required to give a 24 hour notice to our office if you are unable to attend to your appointment. If you should fail to give notice, you will be charged a $25.00 no-show fee each time. This fee will not be reimbursed by your insurance.

Management signature	Patient/Parent signature	Date