BOLING MEDICAL, LLC
899 G SOUTH WEBER ROAD
BOLINGBROOK, IL 60490
630-226-1800
FAX: 630-226-4226
DR. SUMA KAKI, MD

PATIENT INFORMATION

Last Name: ______________________________

First Name: ____________________ MI: __________

Home Address: ______________________________

City:_______________ State:_____ Zip Code:__________

Primary (___) _________________ ❑Cell Phone ❑Home

Secondary (___) _______________ ❑Cell Phone ❑Home

Date of Birth: _______________ ❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner Social Security Number: ______________________________
Employer Name:______________________________
Referring Provider's Name & Number:__________________
____

Race: ❑ African American ❑Asian ❑ Hispanic ❑ Native American ❑ White ❑ Pacific Islander ❑ Other ❑ Declined

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Declined

Please sign up for our **patient portal** today. Our portal gives you access to your health-care data (medication list, laboratory results and medical summary) and most importantly you can communicate with us through the secure portal system. You can ask questions or refill your medications through the portal. Please be advised that it may take up to 3 working days to answer your request.

Patient's Email:
____

Does someone care for you at home? If so, who?
____
Is this person your guardian/legal proxy? ❑ Yes ❑No
What is your primary language? ❑English ❑Spanish ❑ Other
Do you require the assistance of a translator? ❑Yes ❑No
Pharmacy Information:
Name: ______________________________
Location (City & Intersection):
____
Phone:_______________Fax:___________________

Responsible Party (if different from patient information above)

Name: ______________________________ Date of Birth: ______________________
Relationship: ❑Self ❑Spouse ❑Parent ❑Other Social Security Number: __________________
Street Address: ____
City / State / Zip Code: ________________________ Home Phone: ____________________

Minor Consent (Required if the patient is under the age of 18):

I (________________) am the parent and/or legal guardian of __________________________ and I hereby give my consent to Doctors of Internal Medicine / Doctors of Primary Care at McKinney to give medical treatment as deemed necessary by the physician and/or his/her Physician's Assistant or Nurse Practitioner.

______________________________________ ________________________
Signature of Parent/Legal Guardian Date

Signature of Patient ________________________________ **Date**_______________

Please contact for more information: The U.S. department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(202) 619- 6775

I understand that under the Health Portability & Accountability Act of 1996(HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________

Signature: _________________________ Date: _______________