

K. Dean Reeves M.D.

4740 El Monte St – Roeland Park, KS 66205
Phone- (913) 362-1600 Fax- (913) 362-4452

PATIENT INFORMATION

Date: _____

Legal Name:

Dr/Mr/Mrs/Ms/Miss First Middle Last Suffix

Nickname: _____ Date of Birth: _____ Age: _____ Sex: M or F (please circle)

Street Address City State Zip

Home Phone

Voice messages OK

Cell Phone

Text messages OK

Voice messages OK

Work Phone

Voice messages OK

Email Address

Employer

Occupation/Job

Emergency Contact

Relationship

Emergency Phone

Primary Care Physician

Who may we thank for referring you to our practice? _____

HIPAA/Privacy Release Authorization

I, _____, hereby give permission for K. Dean Reeves M.D. and office staff to discuss my medical condition and care &/or billing information with the following person(s):

Name Relationship Phone Number

- Authorized to discuss MEDICAL CONDITION AND CARE
- Authorized to discuss BILLING INFORMATION

Name Relationship Phone Number

- Authorized to discuss MEDICAL CONDITION AND CARE
- Authorized to discuss BILLING INFORMATION

I have been informed of the Privacy Practices and Patient Bill of Rights and have received a copy from Dr. Reeves' website or in Dr. Reeves' office.

Signature of Patient or Patient Representative

Date

EMAIL CONSENT FORM

(PLEASE CHOOSE ONLY ONE OPTION)

Patient Name

I DO NOT consent to email communication of any kind. **I prefer regular mail or phone only.**

I DO consent to email communication at: _____
from Dr. Reeves and his office staff only for direct communication.
PLEASE DO NOT EMAIL MY MEDICAL RECORDS.
I understand that emails will not be encrypted.

I DO consent to email communication at: _____
from Dr. Reeves and his office staff for direct communication
AND
for my medical records when I specifically request them.
They **will not** be automatically emailed to me.
I understand that emails will not be encrypted.

Signature of Patient or Patient Representative

Date