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 Cell Phone Work Phone

_____
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 ONE OPTION ONLY)

I, _____,
Printed Name

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

☐ **DO** consent to email communication for to: _____
PLEASE DO NOT EMAIL ANY OF MY MEDICAL RECORDS.
I understand that these emails will not be encrypted.

☐ **DO** consent to email communication to: _____
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 these emails will not be encrypted.

_____ _____
Signature of Patient or Patient Representative Date