Patient Registration Form

PATIENT INFORMATION:

First Name: _________________________ Middle Initial: ____ Last Name: ___________________________

Date of Birth: ______________Social Security Number__________________ Gender: ___Male ____Female

Mailing Address: ______________________________City: ______________ State: _____Zip:____________

Physical Address (Required for Prescriptions): ____

City: _______________________________ State: ____________________ Zip: _______________________

Home Phone: __________________ Work Phone: __________________ Cell: ________________________

Email: ___________________________________ Dominant Hand (Please circle): Right Left

Marital Status:	Race:	Ethnicity:	Primary Language:
Single___ Married___	Native Hawaiian___ Other Pac. Islander___	Latino/Hispanic___	English___
Divorced___ Widowed___	Asian___ Black/African American___	Not Hispanic___	Spanish___
Legally Separated___	White/Caucasian___ Native American Indian/	Decline to Specify___	Other________________
Decline to Specify___	Alaskan Native___ More than one race___		_
	Other_____________ Decline to Specify___		

WHO IS YOUR PRIMARY CARE PROVIDER? (MUST BE PROVIDED BELOW)		
NAME:		
EMPLOYER		
NAME:	**PHONE#:**	**FAX#:**

PERSON(S) RESPONSIBLE FOR PAYMENT (GUARANTOR):

First Name: _________________________ Middle Initial: ____ Last Name: ____________________________

Date of Birth: _______________ Relationship to patient: ___Self ___Spouse ___Parent/Guardian ___Other

Address: ____City: ______________________________

State: ___________________________ Zip: _________________ Phone #: ___________________________

INSURANCE INFORMATION (NEED COPY OF ALL INSURANCE CARDS):

Primary Insurance Co. _____________________________ Identification #: _________________________

Patient's relationship to person having insurance: ____Self ____Spouse ____Child ____Other

Subscriber or Member: ____

First Name: _________________________ Middle Initial: ____ Last Name: ____________________________

Date of Birth: _______________ Gender: ____Male ____Female

Address: ____

City: __________________________________State: ___________________Zip:______________________

Secondary Insurance Co. _____________________________ Identification #: ________________________

Subscriber or Member: ____

First Name: _________________________ Middle Initial: ____ Last Name: ____________________________

Date of Birth: _______________ Gender: ____Male ____Female

Address: ____

City: __________________________________State: ___________________Zip:______________________

Continued on other side

ALTERNATE CONTACT INFORMATION:

Patient Name: ____________________________ Date of Birth: _______________

Emergency Contact

Name: ____ Relationship: ______________________________

Phone: _____________________________ May we speak to this person about your health? ____Yes ____No

May we speak to anyone else about your health? __Yes __No ***(Please list below)***

Name: _______________________ Relationship: ________________________ Phone: _____________________

PREFERRED PHARMACY (MUST BE PROVIDED BELOW):

NAME:	**LOCATION:**

NO SHOW/SCHEDULING POLICY:

I acknowledge that reminder calls and/or text messages are a courtesy. Patients are ultimately responsible for their appointment time. No show and cancellations less than 24 hours may result in a charge of $25.00 _______ ***(Initial here).***

I acknowledge that **repeat no-shows and cancellations** may result in termination from the practice. I acknowledge that Ali'i Health Center's specialty providers are on-call at the hospital for emergencies. I understand there may be occasions when they are called away from the clinic for an emergency, which may delay your appointment, or cause it to be rescheduled. ***(Initial here):*** ______

PAYMENT AT TIME OF SERVICE:

I acknowledge that all co-payments or deductibles required by a primary insurance policy must be paid at the time of service. Patients without insurance coverage are required to pay at the time of service, and/or make arrangements with the billing department. All past due balances are required at time of service. _______ ***(Initial here)***

I will be charged a fee of $25.00 each check returned by my bank for non-sufficient funds ***(Initial here):***______

PRESCRIPTION MEDICATION GUIDELINES

I acknowledge the following:

1. **ALI`I HEALTH CENTER DOES NOT OFFER CHRONIC PAIN MANAGEMENT OR CHRONIC PSYCHIATRY MANAGEMENT AND WILL NOT PRESCRIBE CHRONIC PAIN MEDICATION(S) OR BENZODIAZEPINE(S)** (for example: chronic daily opiates). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.
3. Refills may take between 48 to 72 hours to process. You may need to be evaluated by your provider to obtain certain refills. ***(Initial here):***______

I authorize and consent to any diagnostic and/or medical treatment under the instruction of my attending physician. I understand that I will be expected to pay my portion for materials and services provided to me at the time of service. I authorize this office or its agent to release to my insurance company, and designated utilization review and/or quality assurance organization, any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.
(Initial here):______

I have read and understand Ali'i Health Center's Notice of Privacy Practices and acknowledge that I have received a copy._______***(Initial here)***
I was presented, and declined a copy of Ali'i Health Center's Notice of Privacy Practices.______ ***(Initial here)***

____ ___________________________
Patient or Legal Representative Signature Date

____ ___________________________
Witness Signature Date

Name: ____________________ Date of Birth: ____________________ Today's Date: ____________________

Allergies / Intolerances

Type of Medication	Type of Reaction
Example Penicillin	*Rash*

History

Past Medical History

Please complete the following in as much detail as possible.

Diagnosis / Conditions *Please circle all that apply.*

Cardiovascular	Heart Disease	Heart Attack	Cardiac Catherization
	Heart Valve Disorder	Atrial Fibrillation	Stent Placement/Angioplasty
	High Blood Pressure	Defibrillator	Pacemaker Implantable
	Elevated Cholesterol	Vascular Disease	Peripheral Arterial Disease
	Palpitations	Blood Clotting Disorder	Deep Venous Thrombosis

Abdominal Aortic Aneurysm Screening (AAA Ultrasound) - Date of Last Exam: ___________

Other: ____

Endocrine	Diabetes (Type 2)	Diabetes (Type 1)	Osteoporosis (Weak bones)
	Overactive Thyroid	Underactive Thyroid	

Fractures (please specify date and type): ____

Gastrointestinal	Heartburn / Reflux	Ulcer	Cirrhosis
	Hepatitis A	Hepatitis B	Hepatitis C
	Diverticulosis	Colon Polyps	Inflammatory Bowel Disease
	Irritable Bowel	Constipation	

Other: ____

Last Colonoscopy: Date of Exam: ____________________ Normal Abnormal Unknown

Hepatitis C Screening in the past? Yes No

Genitourinary	Urinary Tract Infections	Kidney Stones	Overactive Bladder/Incontinence
	Kidney Cysts	Chronic Kidney Disease	Erectile Dysfunction
	Enlarged Prostate	PSA Screen Date of Last Exam: ________________________	
	Are you sexually active? Yes No		
	Sexually Transmitted Infections: Chlamydia Gonorrhea Genital Herpes		

Gynecological / Obstetrics

Cervical Cancer Screening (Pap) Date of Last Exam: ______________________

Dexa Date of Last Exam: ____________________________

Mammogram Date of Last Exam: _______________________

Menstrual Period Date of Last: _________________________

Number of Pregnancies: _________ Number of Deliveries: ________

Neurologic / Psychiatric	Dementia	Stroke	Transient Ischemic Attack (TIA)
	Parkinson's Disease	Depression	Post-Traumatic Stress Disorder
	Neuropathy	Anxiety	
	Other: ____		

Oncologic (Cancer) & Hematologic (Blood Disorders)

Please provide your diagnosis and check if disease is in remission or active.

Lung Cancer	______________	Colon / Rectal Cancer	______________
Breast Cancer	______________	Prostate Cancer	______________
Anemia	______________	Other (Type)	______________

Pulmonary	Asthma	COPD	Asbestos Exposure / Asbestosis
	Emphysema	Pulmonary Nodules	Other: ___________________
Rheumatology / Joint Diseases	Cervical Disc Degeneration	Lumbar Disc Disease	Osteoarthritis
	Rheumatoid Arthritis	Gout	Other: _________________

<u>***Surgical History***</u>

Please provide dates in the space below.

	Year of Surgery		Year of Surgery
Appendix Removal	______________	Hernia Repair	______________
Breast Biopsy / Surgery	______________	Hysterectomy	______________
Cardiac Bypass	______________	Ovarian Removal	______________
Carotid Artery Surgery	______________	Other (type)	______________
Cataract Surgery	______________	Other (type)	______________
Gallbladder Surgery	______________	Other (type)	______________
Device Type & Date	______________	Device Type & Date	______________

Hospitalizations

Please list all dates, reasons and complications for hospitalizations below.

Date of Hospitalization	Reason for Hospitalization	Complications

Family History

Family Member with a History of (Please define who had history and what age if applicable):

Abdominal Aortic Aneurysm	______	Diabetes Mellitus	______
Breast Cancer	______	Mental Illness	______
Colon Cancer	______	Ovarian Cancer	______
Hypertension	______	Prostate Cancer	______
Coronary Artery Disease	______	Stroke	______
Other	______	Other	______
Other	______	Other	______

Social History

Please complete the following information. Please circle all that apply.

Advance Directives

Please bring a copy with you to your first appointmnet.

DNR Five Wishes Guardian Healthcare Surrogate

Living Will Healthcare Power of Attorney None

If none, would you like additional information explaining what these mean? Yes No

Tobacco Use

Never Smoked Former Smoker Current Smoker Every Day Some Days

How much do you or did you smoke? ______ Packs per Day Week

Do you currently use smokelss tobacco? Yes No Type: ____

Used smokelss tobacco in the past? Yes No Type: ____

Most Recent Tobacco or Smokeless Tobacco Use? _____/_______/_______ Number of Years Tobacco Used: ______

E-Cigarette / Vape Use: Current Former Never Used Passive Smoke Exposure: Yes No

Are you interested in quitting? Yes No Ready to Quit? Yes No

Alcohol / Drugs

Alcohol Intake: None Occasional Moderate Heavy

During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages have you consumed? _________

Illicit / Recreational Drug Use: Never In Past Current Type: ___________________________________

General

Total Number in Household? _____ Are you currently employed? Yes No Occupational Exposures? Yes No

Current / Former Occupation: ____

Education: Less than 8th grade 8 9 10 11 12 2yr College 4yr College Post Graduate

Where are you from? ____________________________________

Do you have local family? Yes No Number of Children: _______

Pets? Yes No Able to care for self? Yes No

General Stress Level? Low Medium High Caregiver: Family Friends Other None

Sexually Active? Yes No

Sexual Orientation: Heterosexual Homosexual Bisexual Decline to Answer

Caffeine Intake? None Occasional Moderate Heavy

Exercise? None Occasional Moderate Heavy

Type of Exercise: ____________________________________

Hobbies / Activities: ____________________________________

Diet: Regular Vegetarian Vegan Gluten Free Cardiac Diabetic Other: _______________

Smoke Alarm In Home? Yes No Seat Belts Used Regularly? Yes No

Sunscreen Used Routinely? Yes No

Domestic Violence? Yes No Religious / Spiritual Preference? ____________________________________

Medication Adherence

Do you understand all the medications as you are taking them?	Yes	No
Do you have any financial concerns related to the medication you are taking?	Yes	No
Do you have any other barriers related to the medications you are taking?	Yes	No

Communication Provisions

Do you have any communication barriers? None Cognitive Vision Language Hearing

Does the family / caregiver have any communication barriers? None Cognitive Vision Language Hearing

Medication Information

Note: Please bring ALL medications you are currently using (in their original containers) to your FIRST appointment.

Current Prescription Medications

This may include ointments, inhalers or any items for which you need a prescription, even if you use it rarely.

Name:	**Strength (Formulation)**	**Frequency**	Need refill in the next 90 days?	Supply	Supply
Example: Lisinopril	10mg (tablet)	Once Daily			
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day

____________	No	90 day	30 day
____________	No	90 day	30 day
____________	No	90 day	30 day

Current Non-Prescription Medications

Name:	Strength (Formulation)	Frequency	Purpose
Example: Advil	200mg (capsule)	1 capsule every 6 hours	Headaches

Current Supplements

Name:	Strength (Formulation)	Frequency	Purpose

Pharmacy:

Name: ____________

Location Address / Phone Number: ____________

Mail Order Pharmacy (if different from local pharmacy):

Name: ____________

Location Address / Phone Number: ____________

Discontinued Medications

Name:	Strength (Formulation)	Reason Discontinued
Example: Lisinopril	200mg (capsule)	

Medical Supplies I Use

There are items for which you may need a prescription, such as diabetic shoes, oxygen, prosthetics, etc.

Name:	**Purpose:**
Example: Insulin Syringe	To take insulin for diabetes
___	___
___	___

Immunizations

Please indicate month, day and year last received.

Influenza Vaccine:	Pneumonia Vaccine:	Prevnar Vaccine:	Tetanus Booster:
___	___	___	___
TDAP:	Shingrix (Shingles) Vaccines:	Hepatitis A:	Hepatitis B:
___	___	___	___
Meningitis:	COVID-19 Vaccines & Booster:		
___	___		

Health Maintenance:

Last Colonoscopy: ________________
Last PSA: ________________
Date of Last Bone Density / DEXA Scan: ________________
Date of Last Mammogram: ________________
Date of Last Pap Smear: ________________
Date of Last Menstrual Period: ________________
Age at First Period: _______ Age at First Child _______ Age at Menopause _______
Number of Pregnancies: ______ Number of Living Children: _______
Current Birth Control Method: ___________________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

___________________________________ (PRINT) Patient Name in Full

______/______/______ Date of Birth

______-______-______ Social Security Number

I hereby authorize Ali'i Health Center, and its agents and employees to **release** and / or **obtain** (please check the appropriate space below) information and copies or records pertaining to my medical care and treatment. **I understand and acknowledge that records may include treatment for physical and mental illness, alcohol/drug abuse and or HIV / AIDS test results or diagnoses. <u>This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.*</u> Release of psychotherapy notes requires a separate authorization.**

Release to: __ Obtain from: __

____
Name of designated recipient

____
Address: City, State, Zip Code

____
Phone Number Fax Number

____

Release to: __ Obtain from: __

ALI'I HEALTH CENTER
78-6831 Ali'i Drive, Suite 328
Kailua-Kona, HI 96740
Phone: (808) 747-8321
Fax: (808) 331-8682

PLEASE NOTE: If 25 pages or more are released to Ali'i Health Center, please mail to above address. Please do not fax.

Information to be released:

Dates of Treatment: **From:** _________________________ **To:** ___________________________

□Complete Health Record	□Discharge Summary	□Pathology Reports
□Office Notes	□History & Physical	□Other Specify) _________________
□Consultation Reports	□Laboratory Reports	□Other _________________________
□Operative Report	□Radiology Reports	□Other _________________________

I understand that if I am requesting records/information for release to me or a patient representative:
Laws may prevent certain records being released to the patient in certain situations, records denied for release to the patient may allow patient to request and obtain a review of the denial

My Rights:
I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

Reasonable Fee:
State law provides that a health care provider may charge a reasonable fee.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

____ *Signature of Patient/Patient's Personal Representative***

______________________________ *Printed Name*

________________ *Date Signed*

____
Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.*
***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*
*** For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*

This Authorization will expire in twelve (12) months or__________________________.