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

Ali'i Health Center- Patient Medical History Form

Medications: Name	Dosage	Frequency	Reason for Taking

Allergies

Medication	Food	Environmental	☐ Latex
			☐ Tape
			☐ Iodine

Medical History (Please check all that apply)

Cardiovascular
- ☐Hypertension
- ☐ Angina
- ☐ Rheumatic fever
- ☐ Irregular heartbeat
- ☐ Poor circulation

Respiratory
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Shortness of breath
- ☐ Tuberculosis

Gastrointestinal
- ☐ Ulcers, heartburn
- ☐ Difficulty swallowing
- ☐ Diarrhea, Constipation
- ☐ Hepatitis, Jaundice, Liver disease
- ☐ Hernia
- ☐ Hemorrhoids

Hematology
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Use of blood thinners
- ☐ HIV positive

Renal
- ☐ Kidney Stones
- ☐ Kidney failure/ insufficiency
- ☐ Dialysis

Musculoskeletal
- ☐ Arthritis
- ☐ Difficulty walking
- ☐ Multiple sclerosis

Endocrine
- ☐ Diabetes
- ☐ Thyroid issues
- ☐ Gout

Dermatological
- ☐ Eczema/Impetigo
- ☐ Herpes
- ☐ Blood Clots
- ☐ Bleeding disorder
- ☐ Rash/skin lesions

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Dementia

Miscellaneous
- ☐ Recent weight loss/ Gain
- ☐ Difficulty with vision
- ☐ Difficulty walking
- ☐ Difficulty with hearing
- ☐ Extensive dental work
- ☐ Other (describe)

Females

LMP Date:_________

Number of pregnancies ___

Males
- ☐ Prostate problems

Number of children

Infections

☐ Hepatitis A B C (please circle) ☐ HIV ☐ MRSA ☐ Scabies ☐ Tuberculosis ☐ Body Lice

Health Habits Seatbelt use: ☐ No ☐ Yes Tobacco: ☐ No ☐ Yes ____ x a day Alcohol ☐ No ☐ Yes____ oz per day

Caffeine ☐ No ☐ Yes ____x a day Illegal Drugs ☐ No ☐ Yes, name, type, frequency:_______________________________________

Preventative History:

Date of your last bone density test (If applicable): _____ Result: ___________ Mammogram (if applicable):_____ Result:___________

Date of your last colonoscopy (if applicable): Result: Last Pap Smear (if applicable): Result:

LAST IMMUNIZATION OR TEST

Gardisil (HPV) ☐ Yes Date:____________ ☐ No Herpes Zoster (Shingles) ☐ Yes Date:_____________ ☐ No

Tetanus ☐ Yes Date:______________ ☐ No Pneumonia ☐ Yes Date:______________ ☐ No

Flu Shot ☐ Yes Date:______________ ☐ No TB Skin Test ☐ Yes Date:______________ ☐ No

Surgical History

Date	Type	Hospital	Date	Type	Hospital

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health condition.

____ ________________

Signature of patient, parent, guardian or personal representative **Date**

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__________________________.