Patient Registration Form

__/__/__
Today's Date

Patient Demographics

Legal Last Name | Legal First Name | Middle Initial | Preferred First Name | Birth Date

Permanent Address | Apt. # | City | State | ZIP

Dr. Sarah Canyon

Home Phone | Cell Phone | Primary Care Physician

Social Security # | Language | Email Address

Gender ❑ **Male** ❑ **Female** Marital Status ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**

Race: _____ Ethnicity: _____

Preferred Communication ❑ **Home** ❑ **Cell** ❑ **Work** ❑ **Mail**

Emergency Contact Information

Contact Name | Relationship to Contact | Contact Phone #

Contact Address | Apt. # | City | State | ZIP

Patient Employment Information

Employer | Employment Address | City | State | ZIP

Occupation | Employment Contact | Phone # | Fax #

Employment ❑ **Part Time** ❑ **Full Time** ❑ **Not Employed** ❑ **Self Employed** ❑ **Retired** ❑ **Disabled**

Student ❑ **Part Time** ❑ **Full Time** ❑ **Not a Student** ❑ **Military**

Responsible Party's Information

Legal Name | Social Security # | Date of Birth

Address | Apt. # | City | State | ZIP

Medical Insurance Policy Holder Information

Please present your insurance card(s) & ID with this form.

PRIMARY

Primary Insurance Carrier Name

Insured Name | Insured Birth Date

Subscriber ID

Phone # | Relationship to Patient

SECONDARY

Secondary Insurance Carrier Name

Insured Name | Insured Birth Date

Subscriber ID

Phone # | Relationship to Patient

Authorization to Release Information: I hereby authorize, Kailua Primary Care, to release information acquired in the course of my medical treatment to my insurance companies. I also authorize payment directly to Kailua Primary Care for medical treatment received and claims submitted on an assigned basis.

I Further Understand and agree that: By signing below, either personally or through the person legally empowered to give consent, I authorize Kailua Primary Care, it's employees, agents and other affiliates to provide general care for this and all subsequent requests for care. Kailua Primary Care shall also be entitled to the recovery of all its expenses, including all collection fees, attorney fees and other legal costs that it incurs in connection with the collection or recovery of an unpaid balance on my account and that these costs of collection shall be immediately due and payable upon demand.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ❑ YES ❑ NO

IF YES, WHOM? _____

Signature _____ **Date** _____

Kailua Primary Care - New Patient Medical Information

___/___/_____
Today's Date

Patient Details

Name DOB

Primary Care Physician
Dr Sarah Canyon ☐

Pharmacy Name Pharmacy location Name of Referring Physician

Do you have an Advance Directive or POLST? Yes ☐ No ☐

Allergies/Drug Intolerance *(Please list all allergies and the reaction that occurred)*

Allergic to:	Describe reaction:

Current Active Medical Problems *(Please list medical problems you currently receive treatment for by medication or other services)*

Medical History *(Please list all medical conditions that you have had)*

Women's Health History *(Please describe all relevant conditions)*

Total Pregnancies: Abortions: Miscarriages: Live Births:			
Age of first menstruation: Regular ☐ Irregular ☐ Length of cycle *(days)*:			
Date of 1st day of last menstrual period:		Date and result of last mammogram:	
Date and result of last pap smear:		Date and age of menopause:	
Additional symptoms or concerns:			

Surgical History *(Please list previous surgeries including month/year and surgeon's name and place)*

Type of surgery	Date	Surgeon	Place

Family Medical History

	Illness/condition	Deceased	Cause of Death
Mother		Yes☐ No☐	
Father		Yes☐ No☐	
Grandfather (specify paternal/maternal)		Yes☐ No☐	
Grandmother (specify paternal/maternal)		Yes☐ No☐	
Sisters		Yes☐ No☐	
Brothers		Yes☐ No☐	

Medications *(Please list all medications, both prescriptions and over-the-counter, that you are presently taking)*

Name of medication	Dose/strength	How often do you take this medication?	Reason for taking this medication?	Who prescribed this medication for you?

Social History *(Please tell us about you. Where are you from? Do you work? Are you in school? Are you retired? Who lives with you at home? What is your belief system? Do you have hobbies or interests you would like us to know about?)*

Highest level of education:
Describe your diet:
Type of exercise:

Smoking History *(Please complete the table below. Leave blank if this was or is not relevant to your lifestyle)*

Are you a current or former smoker?	How many packs per day did/do you smoke?	How many years have you smoked?	What year did you quit? (mm/yyyyy)

Substance History *(Please complete the table below. Leave blank if this was or is not relevant to your lifestyle)*

	Type	Amount per week	Number of years?	Years Quit?
Alcohol				
Caffeine				
Recreational drugs				
E-Cigs				

Do you currently see other physicians?

Physician name	Specialty

Health Care Maintenance *(Please describe what preventative health measures you have had done)*

All patients of any age:	
Vaccines *(dates)*: Influenza __/__/__ Tetanus __/__/__ MMR __/__/__ Hep A __/__/__ Hep B __/__/__ Varicella __/__/__	
Date of last Dental exam __/__/__ Eye exam __/__/__	
Other screening tests *(E.g. HIV)*:	
Patients over 50 years old:	
Vaccines *(dates)*: Pneumonia __/__/__ Shingles __/__/__ Pertussis __/__/__	
Blood in stool cards __/__/__ Colonoscopy __/__/__ Lung Cancer (CT chest, 55 to 80 years old) __/__/__	
Other screening tests *(E.g. HIV, PSA, Hep C, etc.)*:	
Patients under 27 years old:	
Vaccines *(dates)*: HPV vaccine __/__/__ Chlamydia screening __/__/__	
Other screening tests:	

Mental Health History *(Please complete the following and use the space below to share any other concerns)*

Over the last 2 weeks, how often have you been bothered by the following problems? *(Please circle your answer)*				
	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3
(For office coding: Total score: _____+_____+_____ = _____)				

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Kailua Primary Care: Amy Kogut, MD and Sarah Canyon, MD, PhD

Address: 328 Uluniu St. #103

City, State, Zip: Kailua, HI 96734

☐ **Please mail records.**
☐ **Please fax records.**

FAX 808-762-1586 **Phone:** 808-451-0555

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative