HAWAII KIDNEY SPECIALISTS
NADA - ONO - KAANEHE - SOLOMON - HAYASHI

Nada, Ono, Ka'anehe & Solomon, LLP. Today's Date: _____

NEW PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	ADDRESS (please include apartment/unit number, if any)		
CITY, STATE, ZIP	PRIMARY PHONE	CELL PHONE	WORK PHONE

BIRTH DATE	SSN	SEX: ❑ MALE ❑ FEMALE	EMAIL
ETHNICITY ❑ HISPANIC or LATINO ❑ NON-HISPANIC or LATINO	RACE	PRIMARY LANGUAGE	MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

INSURANCE / RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE	ID NUMBER	GROUP NUMBER	
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT	SSN	BIRTH DATE
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER	
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT	SSN	BIRTH DATE

PCP (PRIMARY CARE PHYSICIAN)	REFERRING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

PRINT NAME OF PATIENT	SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO:

NAME(S)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:
❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

PRINT NAME OF PATIENT	SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

DO YOU HAVE AN ADVANCED CARE DIRECTIVE? ❑ YES ❑ NO

Nada, Ono, Ka'anehe & Solomon, LLP Today's Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)

PREFERRED PHARMACY:

PREFERRED LABORATORY: ❑ **Diagnostic Lab (DLS)** ❑ **Clinical Lab (CLH)** ❑ **Straub** ❑ **Other:**

IMMUNIZATIONS – Have you had any of the following:

FLU VACCINE? ❑ **YES** ❑ **NO** **IF YES, WHERE AND WHEN:** _____

PNEUMONIA VACCINE? ❑ **YES** ❑ **NO** **IF YES, WHERE AND WHEN:** _____

ALLERGIES

❑ NONE/No Known Allergies	❑ Adhesive Tape	❑ Anesthesia	❑ Aspirin	❑ Codeine
❑ Dairy Products	❑ Iodine/Contrast Dye	❑ Latex	❑ Morphine	❑ Penicillin
❑ Sulfa Drugs	❑ Shellfish/Seafood	❑ **OTHER:**		

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)	CHILD
Kidney Disease				
Diabetes				
High Blood Pressure				
Heart Disease				
Cancer				
Stroke				
Thyroid Disorder				

SOCIAL HISTORY

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employment Status : ❑ Employed (full-time or part-time) ❑ Retired ❑ Unemployed ❑ Disabled ❑ Student

Current/Former Occupation: _____ Current/Former: Employer: _____

Have you used any of the following substances?	Substance	Current User?	Former User?	How often?	How Long? (years)	If stopped, when? (Year)
	TOBACCO	❑ Yes ❑ No	❑ Yes ❑ No			
	ALCOHOL	❑ Yes ❑ No	❑ Yes ❑ No			
	ILLICIT DRUGS	❑ Yes ❑ No	❑ Yes ❑ No			
	Types:	❑ Marijuana ❑ Meth ❑ Cocaine ❑ Heroin ❑ Ecstacy ❑ LSD ❑ Other:_____				

Medical History: Have you ever suffered from any of the following?

❑ NONE of the problems listed			
❑ AIDS or HIV	❑ Diabetes	❑ High Cholesterol	❑ Psychiatric Disorder
❑ Anemia	❑ Edema	❑ Hives or eczema	❑ Rheumatic Fever
❑ Arthritis	❑ Diphtheria	❑ Infectious Mono	❑ Scarlet Fever
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Shortness of Breath
❑ Back Trouble	❑ Glaucoma	❑ Low Blood Pressure	❑ Small Pox
❑ Bladder Infection –UTI	❑ Gout	❑ Measles	❑ Snoring
❑ Bleeding Tendency	❑ Heart Disease	❑ Migraine Headaches	❑ Stroke
❑ Bronchitis	❑ Hemorrhoids	❑ Mitral Valve Prolapse	❑ Tuberculosis
❑ Cancer	❑ Hepatitis	❑ Mumps	❑ Ulcer
❑ Chicken Pox	❑ Hernia	❑ Pneumonia	❑ Venereal Disease
❑ Depression	❑ High Blood Pressure	❑ Polio	❑ Whooping Cough