KA WAI OLA
FAMILY MEDICAL CLINIC
REGISTRATION FORM

TODAY'S DATE:_____

PATIENT DEMOGRAPHICS:
LAST NAME:_____FIRST NAME:_____MIDDLE INITIAL____

DATE OF BIRTH:__/__/____SSN:___-___-____GENDER:____MARITAL STATUS:_____

ADDRESS:_____CITY:_____STATE___ZIP CODE_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE_____

EMAIL:_____ETHNICITY/RACE:_____

PARENT/LEGAL GUARDIAN (ages 18 & under)
NAME:_____RELATIONSHIP:_____DATE OF BIRTH:__/__/____

SSN:___-___-____ADDRESS (if different from above):_____

CITY:_____STATE:____ZIP CODE:_____PHONE:_____

EMERGENCY CONTACT:
NAME:_____RELATIONSHIP:_____PHONE:_____

NAME:_____RELATIONSHIP:_____PHONE:_____

INSURANCE CARRIER:

PRIMARY INSURANCE:	SECONDARY INSURANCE:
CARRIER NAME:_____	CARRIER NAME:_____
MEMBER ID:_____	MEMBER ID:_____
GROUP #:_____	GROUP #:_____
SUBSCRIBER(if not self):_____	SUBSCRIBER (if not self):_____
DATE OF BIRTH:_____	DATE OF BIRTH:_____
SSN:_____	SSN:_____
RELATIONSHIP:_____	RELATIONSHIP:_____

I hereby declare that the above information is true to the best of my knowledge and belief.

SIGNATURE:_____DATE:_____

Ka Wai Ola Family Medical Clinic
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Ka Wai Ola Family Medical Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Ka Wai Ola Family Medical Clinic describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ka Wai Ola Family Medical Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

Ka Wai Ola Family Medical Clinic
94-849 Lumiaina Street, Suite 207
Waipahu, HI 96797.

With this consent, Ka Wai Ola Family Medical Clinic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Ka Wai Ola Family Medical Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Ka Wai Ola Family Medical Clinic may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Ka Wai Ola Family Medical Clinic restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Ka Wai Ola Family Medical Clinic to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Ka Wai Ola Family Medical Clinic may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable

KA WAI OLA
FAMILY MEDICAL CLINIC
84-849 LUMIAINA ST. #207
WAIPAHU, HI 96797

Pediatric Health History Form

Name (optional) _____

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____
CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER: _____
PRESENT HEALTH CONCERNS: _____

_____

MEDICINES/VITAMINS: _____
HERBS/HOME REMEDIES: _____
ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Is this child yours by: ❑ birth ❑ adoption ❑ stepchild ❑ other _____
Please indicate any medical problems during pregnancy ❑ none ❑ specify: _____

_____

Delivery by: ❑ vaginal birth ❑ caesarian If caesarian, why? _____
Birth weight: _____ Birth length: _____ APGAR score 1 min. _____ 5 min. _____
Please indicate any medical problems during the baby's newborn period ❑ none If premature, how early? _____
other problems: _____

_____

NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes If so, how long? _____
Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify: _____

_____

Milk intake now: Type ❑ cow milk (❑ non-fat ❑ 1%fat ❑ 2%fat ❑ whole milk) ❑ soy milk ❑ rice milk
Average ounces per day (Note: 8 ounces are in 1 cup) _____

SLEEP

Hours per night _____ Naps (number & length) _____
Any sleep problems? _____

DEVELOPMENT

At what age did your child: sit alone _____ walk alone _____ say words _____ toilet train (daytime) _____
Girls only: Age at first menstrual period _____

DENTAL HISTORY: Has child been seen by a dentist? ❑ No ❑ Yes If so, how often _____ Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.

Has your child had: ❑ chickenpox ❑ measles ❑ mumps ❑ rubella ❑ meningitis ❑ tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes

Do any household members smoke? ❑ No ❑ Yes

TV —hours per day _____ Computer—hours per day _____ Video Games—hours per day _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates

_____

_____

_____

Hospitalizations/Operations (with dates): _____

_____

Broken bones or severe sprains _____

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-

FAMILY HISTORY: Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

SOCIAL HISTORY:

Birthplace_____ Current (or upcoming) grade:_____

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are the child's parents ❑ married ❑ unmarried ❑ separated ❑ divorced If divorced, when?_____

Parents' occupations: Mother _____ Father _____

Child care situation ❑ parents ❑ others (specify who and hours per day) _____

_____

Concerns about your child: ❑ Alcohol use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior

Is violence at home a concern? ❑ No ❑ Yes Are there guns in the home? ❑ No ❑ Yes

SCHOOL HISTORY:

Did/does your child attend preschool? ❑ No ❑ Yes Current grade_____ Name of school_____

Any concerns about school performance? _____

Any concerns about relationships with: Teachers ❑ No ❑ Yes _____

Students ❑ No ❑ Yes _____

If over 4 years old does your child have a best friend? ❑ No ❑ Yes

Sports / exercise: Type_____ How often?_____ How long (minutes) _____

REVIEW OF ORGAN SYSTEMS: If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine
- ❑ Fevers/chills/excessive sweating
- ❑ Unexplained weight loss / gain

Eyes
- ❑ Squinting/"crossed" eyes/ asymmetric gaze

Ears / Nose / Throat
- ❑ Unusually loud voice/hard of hearing
- ❑ Mouth breathing/snoring
- ❑ Bad breath
- ❑ Frequent runny nose
- ❑ Problems with teeth/gums

Respiratory
- ❑ Cough/wheeze

Gastrointestinal
- ❑ Nausea/vomiting/diarrhea
- ❑ Constipation
- ❑ Blood in bowel movement

Cardiovascular
- ❑ Tires easily with exertion
- ❑ Shortness of breath
- ❑ Fainting

Genitourinary
- ❑ Bedwetting
- ❑ Pain with urination
- ❑ Discharge: penis or vagina

Neurological
- ❑ Headaches
- ❑ Weakness
- ❑ Clumsiness

Muscular / Skeletal
- ❑ Muscle/joint pain

Allergy
- ❑ Hayfever/itchy eyes

Skin
- ❑ Rashes
- ❑ Unusual moles

Psychiatric / Emotional
- ❑ Speech Problems
- ❑ Anxiety/stress
- ❑ Problems with sleep/ nightmares
- ❑ Depression
- ❑ Nail biting/thumbsucking
- ❑ Bad temper/breath holding/ jealousy

Blood / Lymph
- ❑ Unexplained lumps
- ❑ Easy bruising/bleeding

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-