KUMUKAHI
HEALTH + WELLNESS

Registration

Allergies:
_____
_____
_____

Today's Date: / /

Legal Name: Last | First | MI

Preferred Name:

Gender:

Assigned at Birth:
- ☐ Male
- ☐ Female
- ☐ Other: _____

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender (M to F)
- ☐ Transgender (F to M)
- ☐ Transgender (Other)
- ☐ Other: _____

Pronouns:
- ☐ He, Him, His
- ☐ She, Her, Hers
- ☐ They, Them, Theirs
- ☐ Other: _____

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic

Race:
- ☐ Asian
- ☐ White
- ☐ African American
- ☐ Hawaiian
- ☐ Pacific Islander: _____
- ☐ Lantix
- ☐ Multi-Racial
- ☐ Unknown
- ☐ Other: _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Domestic Partner

Date of Birth: / /

Age:

Social Security Number (optional): - -

Home Address:

City:

State:

Zip Code:

Mailing Address: (☐ Check if same as Home Address)

City:

State:

Zip Code:

Cell Phone #: ( ) -

Other Phone #: ( ) -

Email Address:

How may we contact you? (Check all that apply)
- ☐ Provided Mailing Address
- ☐ Provided Email Address
- ☐ Cell Phone
  - May we leave a detailed message? ☐ Yes ☐ No
  - Is texting ok? ☐ Yes ☐ No
- ☐ Other Phone
  - May we leave a detailed message? ☐ Yes ☐ No
  - Is texting ok? ☐ Yes ☐ No

What is your primary source of transportation?
- ☐ Own a car
- ☐ Public Transportation
- ☐ Friends / Relatives
- ☐ Walking
- ☐ Other: _____

What is you preferred Pharmacy?

Who is your Primary Care Provider?

At which location do you receive medical care?

Who is your Primary Insurance Provider?
- ☐ Medicaid / Med Quest
- ☐ Medicare
- ☐ VA
- ☐ Private Insurance/ Employer Provided Insurance
- ☐ Unknown
- ☐ Other: _____
- ☐ None

Who is your Secondary Insurance Provider?
- ☐ Medicaid / Med Quest
- ☐ Medicare
- ☐ VA
- ☐ Private Insurance/Employer Provided Insurance
- ☐ Unknown
- ☐ Other: _____
- ☐ None

Emergency Contact Name:

Relationship to you:

Address:

City:

State:

Zip Code:

Phone #: ( ) -

Is it ok to disclose your medical information to this individual?
☐ Yes ☐ No please Initial: _____

Medical History

Name:	Date of Birth: / /

If you are completing this form for the person named above, what is your relationship to this person? _____

For the following questions check *'yes or no'*, whichever applies, and fill out any question which require a written answer. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1.	**Are you generally in good health?**	☐ Yes ☐ No
2.	**Has there been any changes in our general health within the past year?**	☐ Yes ☐ No
3.	**My last physical exam was on**	**Date:**
4.	**Are you being treated for any medical conditions?** **a. If yes, what condition(s) are being treated?** **i.** _____ **ii.** _____ **iii.** _____ **iv.** _____ **v.** _____ **b. Name of Healthcare provider** **i.** _____	☐ Yes ☐ No
5.	**Do you have / have had any of the following diseases or complications?**	
	a. Damaged heart valves or artificial heart valves (incl. rheumatic heart disease)	☐ Yes ☐ No
	b. Cardiovascular disease (heart trouble, chest pain, high blood pressure)	☐ Yes ☐ No
	c. Sinus trouble	☐ Yes ☐ No
	d. Asthma or hay fever	☐ Yes ☐ No
	e. Persistent cough or cough that produces blood	☐ Yes ☐ No
	f. Tuberculosis	☐ Yes ☐ No
	g. Fainting spells or seizures	☐ Yes ☐ No
	h. Persistent diarrhea, or weight loss	☐ Yes ☐ No
	i. Diabetes	☐ Yes ☐ No
	j. Hepatitis, or liver disease	☐ Yes ☐ No
	k. Thyroid problems	☐ Yes ☐ No
	l. Respiratory problems, emphysema, bronchitis etc.	☐ Yes ☐ No
	m. Arthritis or painful swollen joints	☐ Yes ☐ No
	n. Stomach problems or hyperacidity	☐ Yes ☐ No
	o. Kidney trouble	☐ Yes ☐ No
	p. Epilepsy or other neurological disease	☐ Yes ☐ No
	q. Problems with mental health (depression, anxiety, mood changes)	☐ Yes ☐ No
	i. Are you currently being seen by a behavioral health specialist?	☐ Yes ☐ No
	ii. If you are not seeing a mental health provider, is this something you are interested in?	☐ Yes ☐ No
	r. Cancer **Type:** _____	☐ Yes ☐ No
	s. Other (Please List) **I.** _____ **II.** _____ **III.** _____ **IV.** _____ **V.** _____	

History and Behaviors

For the following questions check '*yes or no'*, whichever applies, and fill out any question which require a written answer. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

A. Do you take any non-prescribed substances (Including alcohol)? ☐ Yes ☐ No

a. If yes, please list which substances below:

i. _____
ii. _____
iii. _____
iv. _____
v. _____

Medications

B. Are you currently taking any medications? ☐ Yes ☐ No

a. If yes, please list all current medications below:

i. _____ Dosage: _____
ii. _____ Dosage: _____
iii. _____ Dosage: _____
iv. _____ Dosage: _____
v. _____ Dosage: _____

No Show / Late Policy

* "**No Show**" (aka "no show, no call") – A patient does not come for their scheduled appointment and does not notify the office.
* "**Same-Day**" appointment – At times, the office may have open appointment slots available on any given day of the week.

A patient is allowed a (10) minute grace period for all appointments and it is the responsibility of the patient to notify the office if they will be arriving later than the grace period. If arriving during the grace period, the appointment will be kept with the understanding that the patient time with the provider will be shorter than scheduled. They may schedule an additional appointment for a later date if needed. If a patient does not call during the grace period or does not call, they will likely need to be rescheduled, but this determination will be made on a case by case basis.

A patient is allowed (3) *no-show's before they are moved to *same-day only status. Should a patient be put on a same-day only status, it is their responsibility to contact the office for appointment availability. If a patient on same-day only status is a no show for their appointment, they will be discharged from care but may reestablish care (6) months from discharge date. In the event this happens, our medical director will contact and return the patient to their primary care provider for continuation of care.

Signature

I have read, understand, and agree to the terms of the No Show / Late Policy stated above.

Signature: _____ Date: _____/_____/_____

Authorized Representative Signature: _____ Date: _____/_____/_____

*Only an authorized legal guardian, health care agent or other authorized personal representative is permitted to sign on behalf of the client named above. A copy of guardianship or other support documents must be provided.

Authorization to Use & Disclosure
Protected Health Information

Name:	**Date of Birth:** / /	**Client ID:**

As the individual named above, I authorize Kumukahi Health + Wellness (KHW) to release copies of, discuss verbally, obtain copies of, my Protected Health Information to/from:

1. _____	**3.** _____
2. _____	**4.** _____

Term

I understand that I do not have to sign this authorization in order to receive services at Kumukahi Health + Wellness (KHW). I may revoke this authorization at any time by notifying my case manager and signing the appropriate field on this form. If I revoke, it would not affect any disclosures already made by Kumukahi Health + Wellness (KHW) based on the initial dates of this authorization. I further understand that once Kumukahi Health + Wellness (KHW) discloses my protected health information to the person(s) named above, it is possible that information could be redisclosed by that person and no longer protected by applicable federal and state law governing the use and disclosure of my health information.

This authorization commences: _____/_____/_____ and will expire on: _____/_____/_____

Authorized Signature

I have read and understand the terms of this authorization, and I have had an opportunity to ask questions about the disclosure of my health information. I knowingly and voluntarily authorize disclosure of my health information as described above.

Signature: _____ Date: _____/_____/_____

*Only an authorized legal guardian, health care agent or other authorized personal representative is permitted to sign on behalf of the client named above. A copy of guardianship or other support documents must be provided.

Revocation

I hereby revoke this authorization.

Signature: _____ Date: _____/_____/_____

Authorized Representative Signature: _____ Date: _____/_____/_____