MEDICAL HISTORY

Patient Name ______________________ Nickname ______________DOB ________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ____________
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ____________)
   - latex
   - nuts ____________
   - fruit ____________
   - other ____________
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis ____________
5. artificial heart valve, repaired heart defect (PFO) ____________
6. pacemaker or implantable defibrillator ____________
7. orthopedic implant (joint replacement) ____________
8. rheumatic or scarlet fever ____________
9. high or low blood pressure ____________
10. a stroke (taking blood thinners) ____________
11. anemia or other blood disorder ____________
12. prolonged bleeding due to a slight cut (INR > 3.5) ____________
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. tuberculosis, measles, chicken pox ____________
15. asthma ____________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________
18. liver disease ____________
19. jaundice ____________
20. thyroid, parathyroid disease, or calcium deficiency ____________
21. hormone deficiency ____________
22. high cholesterol or taking statin drugs ____________
23. diabetes (HbA1c = _______) ____________
24. stomach or duodenal ulcer ____________
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ____________

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis ____________
28. autoimmune disease ____________ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________
30. contact lenses ____________
31. head or neck injuries ____________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, prion disease) ____________
34. viral infections and cold sores ____________
35. any lumps or swelling in the mouth ____________
36. hives, skin rash, hay fever ____________
37. STI/STD/HPV ____________
38. hepatitis (type ____) ____________
39. HIV/AIDS ____________
40. tumor, abnormal growth ____________
41. radiation therapy ____________
42. chemotherapy, immunosuppressive medication ____________
43. emotional difficulties ____________
44. psychiatric treatment ____________
45. antidepressant medication ____________
46. alcohol/recreational drug use ____________

ARE YOU:

47. presently being treated for any other illness ____________
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ____________
49. taking medication for weight management ____________
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches ____________
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person ____________
55. often unhappy or depressed ____________
56. taking birth control pills ____________
57. currently pregnant ____________
58. diagnosed with a prostate disorder ____________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________

ASA ______ (1-6)

Patient Responsibility for Payment for Dental Services

Dear Dental Patients,

To allow us to continue providing you with quality dental services all individuals and families are responsible for the following:

1. Pay their remaining balances in full prior to receiving further non-emergent dental care. If your existing balance is not paid in full, we will not be able to continue elective care and you will be rescheduled when the balance has been paid in full.
2. Payment is due in full at the time of your visit.
3. No one with a dental emergency will be denied services, regardless of their ability to pay; however, elective/follow-up dental work will not be provided until all outstanding dental balances are paid in full.
4. If a patient arrives for their elective dental visit and is unable to pay their estimated charge, that dental appointment will be considered as a "no-show" according to our Dental Program Appointment Compliance Policy.

Steven C. Pine, DDS
Director of Dental Services

I have read and understand, and agree to the above policies.

Printed name of Guarantor:____

Signature of Guarantor:____

Date:____

Hawaiʻi Island Community Health Center

NO-SHOW POLICY ACKNOWLEDGEMENT

(Effective 02/ 05/ 2018)

Definition:

A no-show is defined as a patient who has a scheduled appointment and fails to appear without calling the Center to cancel or reschedule their appointment at least 24 hours prior to their appointment time.

Policy:

1. If a patient is unable to make their scheduled appointment, they are to call at least 24 hours before their appointment to cancel or reschedule.

2. Patients will have the opportunity to reschedule up to three (3) missed appointments.

3. Repeated no-shows on a consistent basis during a six-month period may result in a patient's scheduled appointment being double booked and potentially resulting in longer wait times for a period of six (6) months.

Patient Acknowledgement:

____ ____________

Signature *Date*

____

Print Name

Please fill in all information requested, as it helps us to better serve you.

Patient information is confidential and only used for Hawai'i Island Community Health Center purposes.

PATIENT INFORMATION SUMMARY:

First Name:__________________________Middle Initial:______Last Name: ___________________________________

Date of Birth: ______________ Sex at Birth: () Male () Female

Mailing Address: ____

City:____State:__________________Zip: _____________________

Street Address (*Required for Prescriptions*): ____

City:____State:__________________Zip: _____________________

Home Phone:_______________________Work Phone:________________________Cell: _________________

Email: ____

Marital Status:	**Race:**	**Ethnicity:**	**Primary Language:**
Single ()	Native Hawaiian ()	Latino/Hispanic ()	English ()
Married ()	Other Pac. Islander ()	Not Hispanic ()	Spanish ()
Legally Separated ()	Asian ()		Marshallese ()
Divorced ()	Black/African American ()		Russian ()
	White/Caucasian ()		Filipino ()
	Native American Indian/Alaska Native ()		Chinese ()
	More than one race ()		Japanese ()
			Sign Language ()
			Interpreter? Yes () No ()

Employment Status:

Employed () Employer (where person works):____________________________Phone #__________________

Occupation (what person does): ______________________________

Retired () Disability () Self Employed () Unemployed () Part-time student () Full-time student ()

Person(s) Who is Responsible to Pay *(Guarantor is parent/guardian for patients under 18 years of age and is the patient themselves from 18 years old and up)*:

Last Name:________________________________First Name:______________________Middle Initial: ______

(If Mother) Maiden Name:____________________

Date of Birth: _________________________ Relationship to patient: Self () Spouse () Parent/Guardian () Other ()

Address: ____

City: _______________________________________ State:__________________Zip: ______________________

Phone #: _______________________ Email:____

HOUSEHOLD & FINANCIAL INFORMATION:

Please the complete information listed below. This section helps us receive funding to provide services to the community. Personal identifiable information is never reported and is for grant reporting purposes only. In addition, this information may qualify you to receive additional discounts (medications, Sliding Fee Scale or other services).

Monthly Gross Family Income: Family Size: ______

___$0-$500 ___$500-$1000 ___$1500-$2000 ___$2500-$3000

___$3500-$4000 ___$4500-$5000 ___$5500-$6000 ___No Income

_________Other (please specify)

Farm Worker Status:	**Public Housing:**	**Veteran:**	**Disabled:**
Migrant () Seasonal () Not a farm worker ()	Yes () No ()	Yes () No () *If yes:* Military discharge: Yes () No () Discharge date:______	Yes () No ()

Homeless:		**Refugee Status:**
Yes ()	Transitional Housing ()	Yes () No ()
No ()	Street ()	*If Yes:*
Homeless Shelter ()	Other ()	Country of Origin ______________________

INSURANCE INFORMATION (Need a copy of all insurance cards):

Primary Insurance Co.____________________________________**Identification #:** ____________________

Patient's relationship to person having insurance: Self () Spouse () Child () Other ()

Subscriber or Member:

Last Name: ________________________________ First Name:______________________Middle Initial: ______

Date of Birth: _______________________________ Male () Female ()

Address: ____

City:____State:__________________Zip: ____________________

Secondary Insurance Co._____________________________________**Identification #:** ____________________

Subscriber or Member:

Last Name: ________________________________ First Name:______________________Middle Initial: ______

Date of Birth: _______________________________ Male () Female ()

Address: ____

City:____State:__________________Zip: ____________________

ALTERNATE CONTACT INFORMATION:

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? Name: ____

Relationship: ______________________________ Phone: ____

Parent/Legal Guardian (if under 18 years of age):

Name: __________________________________ Relationship: _______________________________

Phone: __________________________________

If you have a primary care giver please list their name below:

Name: ______________________________ Phone: ______________________________

Do you have an Advance Directive: Yes () No () I decline to provide/discuss Advance Directives ()

*Please provide us with a copy. An Advance Directive form is available to you upon request.

PERMISSION AND RELEASE:

- Hawai'i Island Community Health Center does not participate with Kaiser. I do not have Kaiser.
- If we do not participate with your insurance provider (such as Kaiser) you are responsible for full payment.
- I have disclosed all information about finances(money) and insurance accurately and I am responsible to notify HICHC about any changes in finances (money) or insurance.
- I authorize HICHC, its providers and staff to provide insurance companies with any information needed to receive payment for my visits. This signature may be used on all insurance forms.
- I give permission to Hawai'i Island Community Health Center (HICHC) and all its groups (medical, dental, behavioral, health education, case management) to share information so my family and I receive the best care.
- Today's co-pay or charges a minimum payment for the visit. Any additional charges that are not covered by your insurance will be billed to you. **I understand I am responsible for the balance due by me after insurance and/or slide has been applied.**
- I understand that HICHC does not accept Worker's Compensation and No-Fault (MVA) Insurance and I will disclose this to HICHC so I can be referred to a doctor in the community who can see me.
- All of the information that I am presenting is correct and complete.

By signing I agree to the above permissions and releases

______________________________ ______________________________

Signature (Signed by) (Patient/Person Responsible/Legal Guardian) Date

____

Print Name

______________________________ ______________________________

Print Name of Witness, if someone other than patient is signing Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hawai'i Island Community Health Center keeps a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. Hawai'i Island Community Health Center will not disclose your record to others, unless you direct us to do so of unless the law authorizes of requires us to do so. You may see your record or get more information about it by contacting us.

Hawai'i Island Community Health Center's Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Hawai'i Island Community Health Center Notice of Privacy Practices.

____ ________________
Signature of patient or authorized representative Date

____ ________________
Printed name of signed on behalf of patient Relationship

I have read the Patient's Rights and responsibilities: ________________
This form will be retained in your medical record Initials

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

- To be treated with dignity and respect
- To know the name and professional status of people serving you
- To confidentiality of your medical records
- To receive complete and accurate information about your health related concerns
- To know the effectiveness and possible side effects of all forms of treatment
- To participate in choosing a form of treatment
- To receive verbal education, counseling, and written materials related to your medical condition and/or treatment
- To accept or refuse any care or treatment
- To select and/or change your health care provider
- To review your medical records with the clinical staff provider
- To receive information about services and related costs

Patient Responsibilities

- To provide medical history to the clinical staff including medical records and a list of current medications.
- To provide HICHC with documented proof of income as required by the state of Hawaii (Sliding Fee Applicants only).
- To notify HICHC of any changes in insurance, income status, addresses and phone numbers.
- To treat other patients and HICHC staff with respect. Swearing, threatening, or aggressive behavior could result in immediate discharge from this clinic.
- To notify the HICHC, if you will be late or are unable to make your appointment --you may be rescheduled if you are at least 15 minutes late.
- Your medical, dental, and prescription coverage is a policy between you and your insurance company. Contact them if you have questions about your coverage.
- To pay, on the date of service, any amount due, or an item that may not be covered.
- When accepting care, you agree to follow the treatment plan made by your physician.
- To be responsible for your medications. Request for refills will require at least 48 hours notice or an office visit as required by your physicians.
- To be responsible for your child or children's behavior while in the waiting room or exam room, so as not to disrupt others. Please provide adult supervision for your child/children during your appointment or reschedule your appointment if this cannot be arranged. HICHC staff will not be responsible for minor children.
- No pets allowed within the clinic except service dogs.

By signing below I understand and agree to the above “Patient Rights and Responsibilities.”

____ _____________________________

Signature of Patient (or Responsible Party, if Minor) Date

____

Print Name

Hawaiʻi Island Community Health Center

75-5751 Kuakini Highway, Suite 203, Kailua-Kona, Hawaii 96740 - **Administration** (808) 326-3878 - Fax (808) 329-9370

Video/Photography Release Form

I hereby consent to and authorize the use and reproduction by the Hawai'i Island Community Health Center (HICHC), or anyone authorized by you, of any and all photographs, videotapes, audiotapes involving me and/or my children and family members that were taken on this day. All the forms of media shall be the property of HICHC and can be used for any purpose whatsoever that will assist in promotion and marketing the activities of HICHC.

In signing this release, I acknowledge I have received no compensation and do not expect compensation now or in the future.

Persons covered by this release: ____

____

____

____

____

_________________________________ _________________________ ___________

Name (please print) Authorizing Signature Date