# KOHALA COAST URGENT CARE

62-100 Kaunaoa Dr Kamuela, HI 96743
PH: (808) 880-3321 FAX: (808) 475-0061

## Patient Registration Form

Date: _____ Reason for Visit: _____

**Name**: First: _____ MI: _____ Last: _____

**Date of Birth**: _____ **Gender**: Male Female **SSN**: _____

**Marital Status**: Single Married Divorced Widowed Legally Separated

Primary Language: _____ What is your race: _____

**Home Mailing Address**: _____ **Apt #**: _____

**City**: _____ **State**: _____ **Zip**: _____

**Current address is different from above (ex. hotel)** _____

**Cell Phone**: _____ Ok to send appointment reminders to your cell phone: YES [ ] NO [ ]

**Email** Address: _____ Ok to send appointment reminders to your email: YES [ ] NO [ ]

**Occupation**: _____ **Employer**: _____

**Primary Care Provider** (PCP): _____ **PCP Location**: _____

****INSURANCE INFORMATION** [*PLEASE PROVIDE YOUR INSURANCE CARDS*]**

**Primary** Carrier: _____ Policy #: _____

Subscriber: _____ Relation to patient: _____

**Secondary** Carrier: _____ Policy #: _____

Subscriber: _____ Relation to patient: _____

***The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Kohala Coast Urgent Care, LLC or insurance company to release any information required to process my claims. I also consent medical treatment from Kohala Coast Urgent Care, LLC. _____ (initial)**

Preferred Pharmacy: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

62-100 Kaunaoa Dr, Kamuela, HI 96743 PH: (808) 880-3321 FAX: (808) 475-0061

Patient Name: _____ Date of Birth: _____

## CURRENT MEDICATIONS / SUPPLEMENTS YOU ARE TAKING

| Name of Medication/Supplement | Dosage / Strength | Directions | Prescribed by |
|---|---|---|---|
| *1.* | | | |
| *2.* | | | |
| *3.* | | | |
| *4.* | | | |
| *5.* | | | |
| *6.* | | | |
| *7.* | | | |
| *8.* | | | |
| *9.* | | | |
| *10.* | | | |

## PAST SURGICAL HISTORY

**HAVE YOU EVER HAD SURGERY? YES NO If YES, please list the surgeries and month/year done.**

## PLEASE LIST ALL KNOWN ALLERGIES TO FOOD OR MEDICATION:

## YOUR MEDICAL HISTORY, HAVE YOU EVER HAD:

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Yes / No | Depression | Yes / No | Stroke | Yes / No |
| AIDS or HIV+ | Yes / No | Chronic Lung Disease | Yes / No | Limb Circulation Problems | Yes / No |
| Hepatitis | Yes / No | Epilepsy / Seizures | Yes / No | Kidney Problems | Yes / No |
| Diabetes | Yes / No | Cancer | Yes / No | Thyroid Problems | Yes / No |
| High Blood Pressure | Yes / No | Tuberculosis | Yes / No | Acid Reflux | Yes / No |
| Heart Disease | Yes / No | Shingles | Yes / No | High Cholesterol | Yes / No |
| Back Pain | Yes / No | Neck Pain | Yes / No | Knee Pain – Left / Right | Yes / No |
| Gout | Yes / No | Foot Pain – Left / Right | Yes / No | Shoulder Pain – Left / Right | Yes / No |

Others not listed:

## FAMILY HISTORY

| Problem | | If YES, who? | Problem | | If YES, who? |
|---|---|---|---|---|---|
| Neck Pain | Yes / No | | High Blood Pressure | Yes / No | |

62-100 Kaunaoa Dr, Kamuela, HI 96743 PH: (808) 880-3321 FAX: (808) 475-0061

Patient Name: _____ Date of Birth: _____

| | | | | | |
|---|---|---|---|---|---|
| Cancer: Type: | Yes / No | | Heart Disease | Yes / No | |
| Diabetes | Yes / No | | Stroke | Yes / No | |
| Epilepsy / Seizures | Yes / No | | Back Pain | Yes / No | |
| Others not listed: | | | | | |

Is this for you or your child?

| MENTAL HEALTH HISTORY, HAVE YOU EVER HAD: | | | | | |
|---|---|---|---|---|---|
| anxiety | Yes / No | depressed mood | Yes / No | Decreased need for sleep | Yes / No |
| Panic attacks | Yes / No | Loss of interest | Yes / No | Increased need for sleep | Yes / No |
| Challenges w/forgetfulness | Yes / No | Unable to enjoy activities | Yes / No | Change in appetite | Yes / No |
| Excessive guilt | Yes / No | Hallucinations | Yes / No | Suicidal thoughts | Yes / No |
| Impulsivity | Yes / No | Self-harm | Yes / No | Excessive energy | Yes / No |
| Increased irritability | Yes / No | Crying spells | Yes / No | Excessive worry | Yes / No |
| Excessive tantrums | Yes / No | Impulsivity | Yes / No | Developmental delays | Yes / No |

Do you have any existing mental health diagnosis? If so, please list:

62-100 Kaunaoa Dr, Kamuela, HI 96743 PH: (808) 880-3321 FAX: (808) 475-0061

Patient Name: _____ Date of Birth: _____

Have you experienced any recent traumatic events? If so, please describe:

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the member(s) allowed with a contact phone number:

**Signature:** _____ **Date:** _____

**Name:** _____ **Phone#:** _____ **Relationship:** _____

**Name:** _____ **Phone#:** _____ **Relationship:** _____

The Notice of Privacy Practices is posted in the waiting area and can be found at kohalacoasturgentcare.com.
I consent to the use or disclosure of my protected health information (PHI) by Kohala Coast Urgent Care, LLC for the purpose of treatment, payment, and health care operations.

**Signature:** _____ **Date:** _____

The Patient Rights and Responsibilities is posted in the waiting area and can be found at kohalacoasturgentcare.com.
I understand and agree to comply with the terms and conditions:

**Signature:** _____ **Date:** _____

KOHALA COAST
URGENT CARE

# Patient Medication Waiver

In keeping with our mission to deliver quality, convenient, patient-centered care, KOHALA COAST URGENT CARE, LLC offers its patients in-office dispensing of select medications. Doing so will better ensure you receive your medications as quickly and cost-effectively as possible so treatment can start right away.

Whether you get your prescriptions filled at our clinic is entirely up to you.

Currently we do not process prescription claims with prescription benefit providers and you are welcome to fill your prescription at any pharmacy that accepts your prescription benefit coverage. If you elect to have your prescription dispensed in our clinic for a flat rate, you may not be able to seek reimbursement from your health benefit/prescription benefit plan, even if this is a covered service with your benefit plan.

If you decide to fill your prescription at another pharmacy, your decision will in no way affect the medical care you receive from our health care professionals.

**I hereby acknowledge reading and understanding the above information provided for the in-office dispensing program and have been given an opportunity to ask questions and wish to obtain my prescription from Kohala Coast Urgent Care LLC.**

Print Name: _____ DOB: _____

Patient Signature: _____ Date: _____

KOHALA COAST URGENT CARE

KOHALA COAST URGENT CARE & MOBILE HEALTH
62-100 KAUNAOA DRIVE, KAMUELA, HI 96743
PH: (808) 880-3321 FAX: (808) 475-0061

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize * KOHALA COAST URGENT CARE, LLC to release/obtain the protected health information of

*Patient Name: _____ Birthdate: _____

Address: _____ PhoneNo.: _____

*FROM/ TO Name or Institution: _____

Address: _____ City, State, Zip: _____

Phone No.: _____ Fax No.: _____

*Information to be disclosed:

Date(s) of Service: _____
(We are unable to process requests for future dates)

- o Progress Note(s)
- o IMAGING/EMG/MRI Report(s)
- o Entire Record
- o Billing Record(s)
- o Other/PleaseSpecify_____

*Purposes for the Use and/or Disclosure:

- o At the request of individual
- o Legal Purposes
- o DISABILITY
- o Physician follow –up
- o COREO/CPC+ – PREVENTATIVE HEALTH MEASURES
- o Other: _____

***Unless otherwise revoked, this authorization will expire on the following date or event: _____.**
**If a date or event is not specified, this authorization will expire one year from my date of signature below.**

I understand that I may revoke this authorization at any time by notifying Kohala Coast Urgent Care, LLC, in writing, of my revocation. I understand that the revocation will not apply to any information that was already released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no-longer be protected under the federal privacy regulations.

I hereby release Kohala Coast Urgent Care, LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or any professional opinions, finding, or recommendations as contained in the records released to or by Kohala Coast Urgent Care, LLC.

*Signature: _____ *Print Name: _____ DATE: _____

*Relationship to Patient: _____ *Date: _____

***Items that MUST be completed for authorization to be valid.**

REV 02/14/2024