ALOHA KONA URGENT CARE

A Division of Transformation Health Network

75-5995 Kuakini Hwy. Suite 513 Kailua Kona, HI 96740
Email: office@alohakonaurgentcare.org Phone: (808) 365-2297

Registration Information

Today's Date: _____ /____ /_____

Patient Name: _____,_____Gender: *male / female*
(Last) ***(First)*** ***(Middle Initial)***

Weight: _____ Height: _____ Birth Date: ____ /_____ /_____ Age: _____

Marital Status: _____ Social Security # _____-_____-_____

Mailing address:_____
(Street)
_____
(City) ***(State)*** ***(Zip code)*** ***(Country)***

Home Phone:_____ Mobile phone*: _____*

I consent to receive text messages on my mobile phone (please circle one) Yes / No

Email address: _____

Primary Care Physician's Name: _____ Phone Number: _____

Would you like prayer for anything today? _____

It is important to us that you feel valued as a patient, that means your visit does not end when you leave the building. We will follow up on your visit, test and labs through our escure patient portal. **Please accept the link we will send to you to sign up for the portal.**

Emergency Contact

Name: _____ Relationship to Patient:_____

Phone number: _____

Parent/Guarantor Information (fill out if patient is a minor or if billing address is different than mailing address)

What is the patient's relationship to the guarantor? _____

Guarantor Name: (Last)_____(First)_____ (Middle Initial)_____

Date of Birth _____/_____/_____

Mailing Address (if different than patient):

Address: _____ City:_____

State: _____ Zip code:_____ Country: _____

SSN:_____Phone (if different than patient): _____

Is your visit today due to a work-related injury or an auto accident?
If Yes, please STOP HERE and talk to the receptionist.

Medical History

Briefly explain your reason for seeking medical care today at Aloha Kona Urgent Care: (include duration, location and severity)

_____

_____

Have you taken any medications (prescription or over the counter) for your above problem?

_____

Please list all other medications. If you have your medication list with you, the front desk staff can photocopy it for you.

Medications:	**Dose:**	**Reason for Usage:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **allergic** to any medications? (***list medication*** *and* ***reaction*** *when taken*):

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you **allergic** to any food or environmental agents? _____

List any **major surgeries** (Please use another page if needed):

1. _____ Approx. Date _____
2. _____ Approx. Date _____
3. _____ Approx. Date _____

When was the last time you received a tetanus vaccine? _____/_____/_____ or I don't know

For female patients only:
Do you take any birth control medications? Yes / No If yes, what kind?_____
What was the first day of your last menstrual period? _____/_____/_____

Please mark an (X) by the conditions you may have or have had in the past

_____ Heart Disease _____ Diabetes (I or II) _____ Asthma _____ Genitourinary Disease
_____ High Blood Pressure _____ Thyroid Disease _____ Neurological Disease _____ GI Disease
_____ High Cholesterol _____ Lung Disease _____ Mental Health Problems
_____ Cancer (past / present) Type _____
_____ Other: Please describe: _____

Social History

1. Are you a smoker/vaper: No / Yes. If yes, how many packs a day for how many years? _____ packs a day for _____ years. If you have quit smoking, when did you quit? Approximate date: _____
2. Do you drink alcohol? No / Yes. If yes, how many drinks per week? _____
3. Do you use marijuana or recreational drugs? No / Yes Have you ever used needles to inject drugs? No / Yes

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AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:
Authorization of Treatment: The administration and cost of all medical and surgical procedures, and medication for myself and for my dependents.

_____***Initial*** I acknowledge that a copy of the Notice of Privacy Practices of *Aloha Kona Urgent Care (AKUC)* is available to me upon request. I understand that a copy of this consent form may be used with the same effectiveness as the original. I have read the Notice of Privacy Practices of AKUC provided to me before signing this form.

RECORDS RELEASE FORM

_____***Initial*** I authorize AKUC to release verbally, electronically, and/or in writing confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), immediate family member(s), and/or other healthcare providers.
I authorize AKUC as an after-hour urgent care provider, per standard of urgent care and AKUC policies, to provide a copy of my treatment summary to my identified primary health care provider for continuum of care.
I understand that should I choose to release my medical record to a specific entity, specialist, and/or person(s), such as extended family members, I must specifically state so BELOW in writing to be kept in my medical record.

1) Name: _____
Title/Relation: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____

2) Name: _____
Title/Relation: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____

I authorize the release of the following types of sensitive information by **signing my initials for EACH type I authorize**:
_____Mental Health _____Substance Use _____HIV/AIDS/STIs _____Genetic Testing

_____***Initial*** I also understand that should I want exceptions, regarding the release of my records, I must also state so in writing below.

SCHEDULING AND APPOINTMENTS

_____***Initial*** I acknowledge that AKUC uses a walk-in, same day appointment style of scheduling. In order to be scheduled, I must be physically present at the clinic to secure a spot for the day. Appointments are only made the same day, I cannot schedule a future appointment.

_____***Initial*** I acknowledge that upon securing an appointment, I will be asked to pay the applicable copay or cost of the visit. With exceptions for extraordinary circumstances to be evaluated by AKUC staff, that payment will not be refunded if I miss the appointment or am late, resulting in a no show.

GUARANTEE OF PAYMENT

_____***Initial*** □ **SELF PAY** – I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by Aloha Kona Urgent Care (AKUC).

_____***Initial*** □ **INSURANCE** – Assignment of Benefits: I authorize payment directly to AKUC for all benefits otherwise payable to me. I also acknowledge that AKUC will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance based on the best available information of my current policy and AKUC's current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While AKUC makes every effort to verify my correct insurance information prior to leaving, I understand AKUC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Patient/Responsible Party:_____ _____ ____/____/_____
PRINT SIGN DATE