Account #: _____

PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.

Staff Use Only
Entered by:
Date:

**********PLEASE FILL OUT COMPLETELY AND PLEASE PRINT NEATLY, THANK YOU**********

PATIENTS LAST NAME	PATIENTS FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER:	EMAIL ADDRESS:

CIRCLE ONE: MALE FEMALE	MARITIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED PARTNER

RACE: HAWAIIAN/PACIFIC ISLANDER WHITE AMERICAN INDIAN/AK NATIVE ASIAN BLACK/AFRICAN AMERICAN

ETHNITICITY: NOT HISPANIC OR LATINO HISPANIC OR LATINO

****** SPOUSE/RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN FOR MINOR PATIENTS UNDER 18 YRS OF AGE)****

PARENT/SPOUSE AND/OR LEGAL GUARDIAN NAME:	RELATIONSHIP	DATE OF BIRTH

HOME PHONE:	CELL PHONE:	WORK PHONE & EXT:

ADDRESS:	EMAIL:

PARENT/SPOUSE AND/OR LEGAL GUARDIAN NAME:	RELATIONSHIP	DATE OF BIRTH

HOME PHONE:	CELL PHONE:	WORK PHONE & EXT:

ADDRESS:	EMAIL

HAWAII STATE LAW REQUIRES OUR PRACTICE TO DISCLOSE REQUESTED MEDICAL INFORMATION ABOUT A MINOR TO BOTH OF THE MINORS PARENTS UNLESS A COURT ORDER IS PROVIDED TO OUR PRACTICE SHOWING SOLE CUSTODY IS GRANTED TO ONLY ONE PARENT. *****PROOF OF LEGAL COURT DOCUMENTATION IS REQUIRED****

*******INSURANCE INFORMATION**********

PRIMARY INS:		SECONDARY INS:	
POLICY#		POLICY#	
EMPLOYER:	WORK PHONE & EXT:	EMPLOYER:	WORK PHONE & EXT:

MUST COMPLETE NEXT PAGE

*********PLEASE READ CAREFULLY ************

AUTHORIZING OTHERS TO HAVE ACCESS TO INFORMATION. (**PLEASE NOTE:** MINOR CHILDREN CANNOT BE ACCOMPANIED BY AN ADULT THAT IS NOT THEIR PARENT OR LEGAL GUARDIAN SUCH AS GRANDPARENTS UNLESS LISTED BELOW**)** OFFICE POLICY REQUIRES AN ADULT TO ACCOMPANY ANY MINOR CHILD TREATED BY OUR PRACTICE. PLEASE LIST BELOW **ANY** PERSON/FAMILY MEMBERS/SPOUSE YOU AUTHORIZE TO ACCOMPANY YOURSELF OR YOUR CHILD, WHO MAY CONSENT AND AUTHORIZE ON YOUR BEHALF TO PROVIDE TREATMENT OR SERVICES (INCLUDING VACCINATIONS) AND ALLOW THE DISCLOSURE OF YOURS OR YOUR CHILDS PERSONAL HEALTH INFORMATION INCLUDING BILLING. (THIS CONSENT MAY BE REVOKED AT ANY TIME BY COMPLETING A NEW PATIENT REGISTRATION FORM).

PERSON #1:	RELATIONSHIP:	PHONE:
PERSON#2	RELATIONSHIP:	PHONE:

IMMUNIZATION POLICY: I UNDERSTAND THAT PANIOLO PEDIATRIC AND FAMILY MEDICINE FIRMLY BELIEVES IN THE EFFICACY AND SAFETY OF VACCINES TO PREVENT SERIOUS ILLNESS AND SAVE LIVES WHEN GIVEN PER THE AAP (AMERICAN ACCADEMY OF PEDIATRICS) RECOMMENDED SCHEDULE (THIS EFFICACY IS UNKNOWN WHEN DIVIATED). I UNDERSTAND THE POLICY AND AGREE TO BE COMPLIANT BY FOLLOWING THE AAP RECOMMENDED SCHEDULE FOR WELL CHILD CARE & IMMUNIZATIONS.

PRACTICE POLICY REQUIRES NEWBORNS TO COMPLETE THEIR 2 MONTH VACCINATIONS NO LATER THAN 3 MONTHS OF AGE AND BE FULLY VACCINATED BY 2 YRS OF AGE. TEENS MUST RECEIVE THEIR VACCINES BY AGE 13 (NEW TEENS TO THE PRACTICE WHO HAVE NOT HAD THEIR TEEN VACCINES AGREE TO RECEIVE THESE UPON ESTABLISHING CARE.

PATIENT/PARENT SIGNATURE: _____PRINT _____DATE_____

APPOINTMENTS: I UNDERSTAND AS A COURTESY REMINDER THE OFFICE WILL ATTEMPT TO CALL/TEXT/EMAIL 1-3 DAYS PRIOR TO MY SCHEDULED APPOINTMENT. I AGREE TO HAVE TEXT MESSAGES OR MESSAGES LEFT ON MY VOICE MAIL AND/OR ANSWERING MACHINE FOR THE PHONE NUMBERS I HAVE PROVIDED. IT IS MY RESPONSIBILITY TO NOTIFY PANIOLO WHEN MY CONTACT INFORMATION CHANGES. PANIOLO PROVIDERS AGREE TO MAKE EVERY EFFORT TO STAY ON SCHEDULE AND APPRECIATE THE SAME RESPECT IN MY SHOWING ON TIME FOR MY APPOINTMENTS. IF I HAVE A NEED TO CANCEL OR RESCHEDULE, I AGREE TO DO THIS 24 HOURS PRIOR TO MY APPOINTMENT. I UNDERSTAND A $25.00 FEE MAY BE CHARGED FOR NOT CANCELLING MY APPOINTMENT AND IS NOT BILLABLE OR REIMBURSABLE BY MY INSURANCE.

PATIENT SIGNATURE _____PRINT_____ DATE_____

FINANCIAL RESPONSIBILITY: I UNDERSTAND THAT MY INSURANCE POLICY IS A CONTRACT BETWEEN ME AND MY INSURANCE. I ASSUME FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED TO ME OR MY CHILD THAT ARE NOT COVERED BY MY INSURANCE COMPANY. I UNDERSTAND THAT PAYMENT INCLUDING ALL COPAYS, DEDUCTIBLE AND NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE REGARDLESS IF MY CHILD IS BEING ACCOMPANIED BY AN AUTHORIZED FAMILY MEMBER OR PERSON. I REQUEST AND AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO PANIOLO PEDIATRICS AND FAMILY MEDINE INC. I UNDERSTAND THAT IF I CHOOSE TO LEAVE THE PRACTICE UPON WRITTEN REQUEST MY RECORDS OR MY CHILDS RECORDS MAY BE FORWARDED TO ANOTHER PHYSICIAN FREE OF CHARGE BUT THAT IF I CHOOSE TO HAVE A COPY MADE THERE IS A $15 PROCESSING FEE FOR THE 1ST 15 PAGES AND $.25 EACH ADDITIONAL PAGE THAT IS NOT BILLABLE OR REIMBURSABLE BY MY INSURANCE COMPANY.

PATIENT/PARENT SIGNATURE_____PRINT_____ DATE _____

AUTHORIZATION AND RELEASE: TO THE BEST OF MY KNOWLEDGE THE INFORMATION I HAVE GIVEN ON THIS FORM IS CORRECT. I AUTHORIZE PANIOLO PEDIATRIC AND FAMILY MEDICINE INC AND THEIR PHYSICIANS TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAM RENDERED TO ME OR MY CHILD TO MY HEALTH INSURANCE CARRIER. I HAVE REVEIWED AND UNDERSTAND I MAY REQUEST A COPY OF THE OFFICE'S NOTICE OF PRIVACY PRACTICES. I CONSENT TO THEIR DISCLOSURE OF MY OR MY CHILDS PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

PATIENT/PARENT SIGNATURE_____PRINT_____DATE _____

TO PROVIDE OUR PATIENTS WITH THE BEST CARE AND FOCUS ENTIRELY ON THE CONVERSATION AND VISIT, THE CLINIC USES A SECURE AI TOOL TO TRANSCRIBE THE VISIT AND DRAFT A CLINICAL NOTE. ALL DATA IS HANDLED ACCORDING TO HIPAA REGULATIONS, ENCRYPTED, AND NEVER SOLD. THESE NOTES ARE REVIEWED FOR ACCURACY. YOU MAY OPT OUT AT ANY TIME BY VERBALLY EXPRESSING YOUR WISHES TO NOT USE THIS TECHNOLOGY.

PATIENT/PARENT SIGNATURE_____PRINT_____DATE _____