Acco	oun	t #:		
			DEFUSE	

PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.

Staff Use Only	
Entered by:	
Date:	

************PLEASE FILL OUT	COMPLETELY AN	ND PLEASE PRINT N	EATLY,	THANK YOU	J*****	******
PATIENTS: LAST NAME FIRST	NAME	MIDDLE NAME		PREFERR	ED NAMI	DATE OF BIRTH
MAILING ADDRESS		CITY		ST	ATE	ZIP CODE
HOME PHONE	CELL PHONE	•		WORK PHO	NE	
PHYSICAL ADDRESS		CITY		STATE		ZIP CODE
CIRCLE: MALE FEMALE OTHER	MARITIAL STATUS	: SINGLE MA	RRIED	DIVORCED	WIDO	OWED PARTNER
RACE: HAWAIIAN/PACIFIC ISLANDER	WHITE AMERIC	AN INDIAN/AK NATIV	/E ASI	AN BLACK	/AFRICAN	AMERICAN OTHER
ETHNITICITY: NOT HIS	PANIC OR LATINO	HISP	ANIC OR	RLATINO		
EMPLOYER				DRIVER LIC # 8	& STATE IS	SSUED
SPOUSES NAME:		PHONE:	•		DOB:	
PROVIDE PARENT/LEGAL GUARD	IAN INFORMATI	ON (MINOR PATIE	NTS OR	>18 ADULT	WITH P	OA GUARDIANS)
MOTHER AND/OR LEGAL GUARDIAN NA	AME:				D	ATE OF BIRTH
HOME PHONE:	CELL PHONE:			WORK PH	IONE & E	XT:
ADDRESS:				EMAIL:		
FATHER AND/OR LEGAL GUARDIAN NA	ME:				D	DATE OF BIRTH
HOME PHONE:	CELL PHONE:			WORK PH	IONE & E	XT:
ADDRESS:				EMAIL		
HAWAII STATE LAW REQUIRES OUR PR MINORS PARENTS UNLESS A COURT OF PARENT. *****PROOF OF LEGAL COUF	RDER IS PROVIDED	TO OUR PRACTICE S	HOWIN	FORMATION IG SOLE CUST	ABOUT A	A MINOR TO BOTH OF THE GRANTED TO ONLY ONE
*	*****INSURAN	NCE INFORMATION	*****	*****		
PRIMARY INS:		SECONDAR	Y INS:			
POLICY#		POLICY#				
SUBSCRIBER:		SUBSCRIE	ER:			
EMPLOYER:		EMPLOYE	R:			

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

ADULTS AUTHORIZING OTHERS TO HAVE ACCESS TO INFORMATION (example: <18 YR OLDS WHO GIVE ACCESS TO PARENTS OR <65 YR OLDS AUTHORIZING THEIR CHILDREN TO HAVE ACCESS) OR MINOR CHILDREN WHO WILL BE SEEN WHILE ACCOMPANIED BY AN ADULT THATS NOT THEIR PARENT OR LEGAL GUARDIAN (example: GRANDPARENTS) PLEASE LIST BELOW FAMILY MEMBERS/PERSONS YOU AUTHORIZE TO ACCOMPANY YOU/YOUR CHILD, PROVIDE CONSENT FOR TREATMENT AND OTHER SERVICES (INCLUDING VACCINATIONS) AND AUTHORIZE DISCLOSURE OF YOUR OR YOUR CHILDS PERSONAL HEALTH INFORMATION INCLUDING BILLING. (CONSENT MAY BE REVOKED ANY TIME BY COMPLETING A NEW REGISTRATION FORM).

PERSON#2: RELATIONSHIP: PERSON#2: RELATIONSHIP: PHONE: RELATIONSHIP: PHONE: RELATIONSHIP: PHONE: RELATIONSHIP: PHONE: RELATIONSHIP: PHONE: RELATIONSHIP: PHONE: RELATIONSHIP: RELATIONSHIP: PHONE: RELATIONSHIP: RELATIONSHIP: PHONE: RELATIONSHIP: RELATIONSHIP: RELATIONSHIP: PHONE: RELATIONSHIP: RE			
IMMUNIZATION POLICY(MINORS UNDER 18 YRS OF AGE ONLY): I UNDERSTAND THAT PANIOLO PEDIATRIC AND FAMILY MEDICINE FIRMLY BELIEVES IN THE EFFICACY SUNDENS OF A PET YOR VACCINES TO PREVENT SERIOUS ILLNESS AND SAVE LIVES WHEN GIVEN PER THE CDC RECOMMENDED SCHEDULE (THIS EFFICACY IS UNKNOWN WHEN A LITERED). I UNDERSTAND THE POLICY AND AGREE TO BE COMPLIANT BY FOLLOWING THE CDC 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: 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 ANDIOR ANSWERING MACHINE FOR THE PHONE NUMBERS I HAVE PROVIDED. IT IS MY RESPONSIBILITY TO NOTIFY PANIOLO WHEN MY CONTACT INFORMATION CHANGES, PANIOLO PROVIDEDS AGREE TO MAKE EVERY PETFORT 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/PARENT SIGNATURE PRINT DATE PRINT	PERSON #1:	RELATIONSHIP:	PHONE:
FIRMLY BELIEVES IN THE EFFICACY AND SAFETY OF VACCINES TO PREVENT SERIOUS ILLNESS AND SAVE LIVES WHEN GIVEN PER THE COC RECOMMENDED SCHEDULE (THIS EFFICACY IS UNKNOWN WHEN ALTERED); I UNDERSTAND THE POLICY AND AGREE TO BE COMPLIANT BY FOLLOWING THE COC 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 CALLITEXTEMAL 1-3 DAYS PRIOR TO MY SCHEDULED APPOINTMENT. I AGREE TO HAVE TEXT MESSAGES OR MESSAGES LEFT ON MY VOICE MAIL ANDIOR ANSWERNOR 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 RESPORT IN MY MONOR ON TIME FOR MY APPOINTMENTS. IF HAVE A NEED TO CANCEL OR RESCHEDULE I AGREE TO DO THIS 24 HOURS PRIOR TO MY APPOINTMENT. LIUNDERSTAND A \$25.00 FEE MAY BE CHARGED FOR NOT CANCELLING MY APPOINTMENT AND IS NOT BILLABLE OR REIMBURSABLE BY MY INSURANCE. PATIENT/PARENT SIGNATURE PRINT DATE FINANCIAL RESPONSIBILITY: LUNDERSTAND 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 PRAYMENT INCLUDING ALL COPAYS, DEDUCTIBLE AND NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVIC. FINANCIAL RESPONSIBILITY TO PANIOLO PEDIATRICS AND FAMILY MEDICENE INC. I LIVDERSTAND THAT IT I 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 STS PROCESSING FEE FOR T	PERSON#2	RELATIONSHIP:	PHONE:
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