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	FIRST NAME	MIDDLE NAME	PREFERRED NAME	DATE OF BIRTH

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

CIRCLE: MALE FEMALE OTHER | MARITIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED PARTNER

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

ETHNITICITY: NOT HISPANIC OR LATINO HISPANIC OR LATINO

EMPLOYER	DRIVER LIC # & STATE ISSUED

SPOUSES NAME:	PHONE:	DOB:

PROVIDE PARENT/LEGAL GUARDIAN INFORMATION (MINOR PATIENTS OR >18 ADULT WITH POA GUARDIANS)

MOTHER AND/OR LEGAL GUARDIAN NAME:	DATE OF BIRTH

HOME PHONE:	CELL PHONE:	WORK PHONE & EXT:

ADDRESS:	EMAIL:

FATHER AND/OR LEGAL GUARDIAN NAME:	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#

SUBSCRIBER:	SUBSCRIBER:

EMPLOYER:	EMPLOYER:

TURN OVER

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

IMMUNIZATION POLICY(MINORS UNDER 18 YRS OF AGE ONLY): 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 CDC RECOMMENDED SCHEDULE (THIS EFFICACY IS UNKNOWN WHEN ALTERED). 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: 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/PARENT 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 MEDICINE 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 THE **HIPAA NOTICE OF PRIVACY PRACTICES** AND UNDERSTAND I MAY REQUEST A COPY OF THE OFFICE'S NOTICE AT ANY TIME. I CONSENT TO THE DISCLOSURE OF MY OR MY CHILDS PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

PATIENT/PARENT SIGNATURE_____PRINT_____DATE _____