Patient Registration Form

__/__/____
Today's Date

Patient Demographics

Social Security # | Legal Last Name | Legal First Name | Middle Initial | Preferred First Name

Permanent Address | Apt. # | City | State | ZIP

☐ **Dr. Kogut** ☐ **Dr. Canyon**

Home Phone | Cell Phone | Primary Care Physician

Birth Date | Language | Email Address

Gender ❑ **Male** ❑ **Female** Marital Status ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**

Race: _____ Ethnicity: _____

Preferred Communication ❑ **Home** ❑ **Cell** ❑ **Work** ❑ **Mail**

Emergency Contact Information

Contact Name | Relationship to Contact | Contact Phone #

Contact Address | Apt. # | City | State | ZIP

Patient Employment Information

Employer | Employment Address | City | State | ZIP

Occupation | Employment Contact | Phone # | Fax #

Employment ❑ **Part Time** ❑ **Full Time** ❑ **Not Employed** ❑ **Self Employed** ❑ **Retired** ❑ **Disabled**

Student ❑ **Part Time** ❑ **Full Time** ❑ **Not a Student** ❑ **Military**

Responsible Party's Information

Legal Name | Social Security # | Date of Birth

Address | Apt. # | City | State | ZIP

Medical Insurance Policy Holder Information

Please present your insurance card(s) & ID with this form.

PRIMARY

Primary Insurance Carrier Name

Insured Name | Insured SSN | Insured Birth Date

Address | City/State/ZIP

Phone # | Relationship to Patient

SECONDARY

Secondary Insurance Carrier Name

Insured Name | Insured SSN | Insured Birth Date

Address | City/State/ZIP

Phone # | Relationship to Patient

Authorization to Release Information: I hereby authorize I_gjs_Npgk_pwA_pc (INA) to release information acquired in the course of my medical treatment to my insurance companies. I also authorize payment directly to INA for medical treatment received and claims submitted on an assigned basis.

I Further Understand and agree that: By signing below, either personally or through the person legally empowered to give consent, I authorize INA, its employees, agents and other affiliates to provide general care for this and all subsequent requests for care. INA shall also be entitled to the recovery of all its expenses, including all collection fees, attorney's fees and other legal costs, that it incurs in connection with the collection or recovery of an unpaid balance on my account and that these costs of collection shall be immediately due and payable upon demand.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ❑ YES ❑ NO

IF YES, WHOM? _____

Signature _____ **Date** _____

Kailua Primary Care - New Patient Medical Information

___/___/_____
Today's Date

Patient Details

Name DOB

Primary Care Physician *(tick one)*
Dr Kogut ☐ Dr Canyon ☐

Pharmacy Name Pharmacy location Name of Referring Physician

Do you have an Advance Directive or POLST? Yes ☐ No ☐

Allergies/Drug Intolerance *(Please list all allergies and the reaction that occurred)*

Allergic to:	Describe reaction:

Current Active Medical Problems *(Please list medical problems you currently receive treatment for by medication or other services)*

Medical History *(Please list all medical conditions that you have had)*

Women's Health History *(Please describe all relevant conditions)*

Total Pregnancies: Abortions: Miscarriages: Live Births:			
Age of first menstruation: Regular ☐ Irregular ☐ Length of cycle *(days)*:			
Date of 1st day of last menstrual period:		Date and result of last mammogram:	
Date and result of last pap smear:		Date and age of menopause:	
Additional symptoms or concerns:			

Surgical History *(Please list previous surgeries including month/year and surgeon's name and place)*

Type of surgery	Date	Surgeon	Place

Family Medical History

	Illness/condition	Deceased	Cause of Death
Father		Yes ☐ No ☐	
Mother		Yes ☐ No ☐	
Grandfather (specify paternal/maternal)		Yes ☐ No ☐	
Grandmother (specify paternal/maternal)		Yes ☐ No ☐	
Sisters		Yes ☐ No ☐	
Brothers		Yes ☐ No ☐	

Medications *(Please list all medications, both prescriptions and over-the-counter, that you are presently taking)*

Name of medication	Dose/strength	How often do you take this medication?	Reason for taking this medication?	Who prescribed this medication for you?

Social History (*Please tell us about you. Where are you from? Do you work? Are you in school? Are you retired? Who lives with you at home? What is your belief system? Do you have hobbies or interests you would like us to know about?)*

Highest level of education:
Describe your diet:
Type of exercise:

Smoking History (*Please complete the table below. Leave blank if this was or is not relevant to your lifestyle)*

Are you a current or former smoker?	How many packs per day did/do you smoke?	How many years have you smoked?	What year did you quit? (mm/yyyyy)

Substance History (*Please complete the table below. Leave blank if this was or is not relevant to your lifestyle)*

	Type	Amount per week	Number of years?	Years Quit?
Alcohol				
Caffeine				
Recreational drugs				
E-Cigs				

Do you currently see other physicians?

Physician name	Specialty

Health Care Maintenance (*Please describe what preventative health measures you have had done)*

All patients of any age:	
Vaccines *(dates)*: Influenza __/__/__ Tetanus __/__/__ MMR __/__/__ Hep A __/__/__ Hep B __/__/__ Varicella __/__/__	
Date of last Dental exam __/__/__ Eye exam __/__/__	
Other screening tests *(E.g. HIV)*:	
Patients over 50 years old:	
Vaccines *(dates)*: Pneumonia __/__/__ Shingles __/__/__ Pertussis __/__/__	
Blood in stool cards __/__/__ Colonoscopy __/__/__ Lung Cancer (CT chest, 55 to 80 years old) __/__/__	
Other screening tests *(E.g. HIV, PSA, Hep C, etc.)*:	
Patients under 27 years old:	
Vaccines *(dates)*: HPV vaccine __/__/__ Chlamydia screening __/__/__	
Other screening tests:	

Mental Health History *(Please complete the following and use the space below to share any other concerns)*

Over the last 2 weeks, how often have you been bothered by the following problems? *(Please circle your answer)*				
	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3
(For office coding: Total score: _____+_____+_____ = _____)				