Aiea Pediatrics, LLC
Brent K. Tamamoto, M.D.
99-080 Kauhale Street, C-22, Aiea, HI 96701
Office: (808) 487-1600 Fax: (808) 487-1601

NEW PATIENT REGISTRATION PACKET

Please print legibly so that we can input the correct patient information

PATIENT'S INFORMATION

PATIENT'S LAST NAME			PATIENT'S FIRST NAME		MI	SUFFIX
STREET ADDRESS			CITY, STATE AND ZIP CODE			
DATE OF BIRTH	AGE	GENDER	SSN	ETHNICITY		

PARENT INFORMATION

MOTHER'S LAST NAME		MOTHER'S FIRST NAME		MI	SUFFIX
DATE OF BIRTH	MARITAL STATUS	HOME PHONE #	CELL PHONE #	WORK PHONE #	
STREET ADDRESS (IF DIFFERENT FROM ABOVE)		CITY, STATE AND ZIP CODE			
SSN	ETHNICITY	EMAIL			
EMPLOYER		OCCUPATION			

FATHER'S LAST NAME		FATHER'S FIRST NAME		MI	SUFFIX
DATE OF BIRTH	MARITAL STATUS	HOME PHONE #	CELL PHONE #	WORK PHONE #	
STREET ADDRESS (IF DIFFERENT FROM ABOVE)		CITY, STATE AND ZIP CODE			
SSN	ETHNICITY	EMAIL			
EMPLOYER		OCCUPATION			

LEGAL GUARDIAN INFORMATION (If applicable, legal papers are required)

LEGAL GURADIAN'S LAST NAME		LEGAL GUARDIAN'S FIRST NAME		MI	SUFFIX
DATE OF BIRTH	MARITAL STATUS	HOME PHONE #	CELL PHONE #	WORK PHONE #	
STREET ADDRESS (IF DIFFERENT FROM ABOVE)		CITY, STATE AND ZIP CODE			
SSN	ETHNICITY	EMAIL			

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Aiea, Hawaii96701

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Consent to Aiea Pediatrics LLC Office Policy and Procedures:

I have read and understand the Policy and Procedures for Aiea Pediatrics LLC. I agree to abide by the terms set forth within the Policy and Procedures. I may ask for a copy of the Policy and Procedures at any time from a Staff Member.

Print Name of Parent/Guardian:	Date:
Signature of Parent/Guardian:	

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Insurance Information

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PRIMARY INSURANCE

SUBSCRIBER'S LAST NAME:		SUBSCRIBER'S FIRST NAME:
SUBSCRIBER'S DATE OF BIRTH:	NAME OF INSURANCE: (HMSA, UHA)	MEMBER'S NUMBER:
RELATIONSHIP TO PATIENT: (CIRCLE ONE) FATHER MOTHER LEGAL GUARDIAN SELF		
EMPLOYER:	OCCUPATION:	BUSINESS PHONE:

SECONDARY INSURANCE

SUBSCRIBER'S LAST NAME:		SUBSCRIBER'S FIRST NAME:
SUBSCRIBER'S DATE OF BIRTH:	NAME OF INSURANCE: (HMSA, UHA)	SUBSCRIBER'S MEMBER NUMBER:
RELATIONSHIP TO PATIENT: (CIRCLE ONE) FATHER MOTHER LEGAL GUARDIAN SELF		
EMPLOYER:	OCCUPATION:	BUSINESS PHONE:

PATIENT REFERRED BY:

NAMES OF IMMEDIATE FAMILY MEMBERS WHO ARE PATIENT'S OF DR. TAMAMOTO:

NAME:	DATE OF BIRTH	RELATIONSHIP TO PATIENT

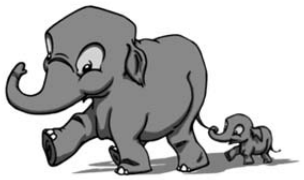
PLEASE READ THE FOLLOWING AND SIGN BELOW:

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF CHARGES AT THE TIME SERVICE IS RENDERED. I UNDERSTAND THAT IF I DO NOT FURNISH ALL NECESSARY INFORMATION TO INSURE PAYMENT FROM INSURANCE COVERAGE THAT I AM FULLY RESPONSIBLE FOR THE CHARGES AND ANY COLLECTION FEES. I ALSO GIVE DR. TAMAMOTO PERMISSION TO EVALUATE AND TREAT MY CONDITION.

I AUTHORIZE DR. TAMAMOTO TO DISCLOSE MY HEALTH INFORMATION, INCLUDING COPIES OF MEDICAL RECORDS TO: (A) ANY HEALTH INSURANCE PLAN OR COMPANY THAT PROVIDES INSURANCE COVERAGE FOR ME OR THE NAMED PATIENT, FOR THE PURPOSE OF PAYMENT OF CHARGES; (B) ANY INSURANCE COMPANY THAT PROVIDES LIABILITY INSURANCE TO DR. TAMAMOTO, TO EVALUATE CLINICAL PERFORMACE; (C) ANY WORKERS' COMPENSATION, NO-FAULT OR ADMINISTRATIVE PROCEEDING FOR THE PURPOSE OF EVALUATING MY MEDICAL CONDITION. THIS AUTHOIZATION SHALL COVER THE PERIOD OF TIME FROM MY LAST VISIT.

I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME. THIS AUTHORIZATION SHALL END TWO YEARS AFTER THE DATE OF MY LAST VISIT.

NAME OF PATIENT:	SIGNATURE (Not necessary if younger than 18):
NAME OF PERSON SIGNING, IF NOT PATIENT:	SIGNATURE:
RELATIONSHIP TO PATIENT:	DATE:



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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY POLICIES AND PRACTICES
FOR

AIEA PEDIATRICS LLC
BRENT K. TAMAMOTO, M.D.

I have read the Notice of Privacy Policies and Practice (the "Notice") that is available in the office of Aiea Pediatrics LLC. I was informed that I may also obtain a printed copy of the Notice from any Staff Member. I hereby acknowledge that I have read and/or received from the office of Brent K. Tamamoto, M.D. a copy of the Notice.

I authorize the office of Brent K. Tamamoto M.D. to contact me at Home, Cellular, or Business number concerning any test results, appointment reminders, scheduling, and/or any medical information.

NAME OF PATIENT	SIGNATURE (Not necessary if younger than 18)
NAME OF PERSON SIGNING IF NOT PATIENT	SIGNATURE
RELATIONSHIP TO PATIENT	DATE

OPTIONAL

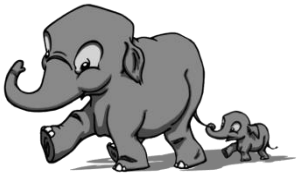
I also authorize the office of Brent K. Tamamoto, M.D. to also disclose and discuss any information regarding my medical care, including appointments and financial concerns, to any person listed below:

NAME OF AUTHORIZED PERSON	RELATIONSHIP TO PATIENT
CONTACT NUMBER	DATE

NAME OF AUTHORIZED PERSON	RELATIONSHIP TO PATIENT
CONTACT NUMBER	DATE

NAME OF AUTHORIZED PERSON	RELATIONSHIP TO PATIENT
CONTACT NUMBER	DATE

SIGNATURE OF PARENT OR LEGAL GUARDIAN



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MEDICAL / FAMILY HISTORY QUESTIONAIRE

PATIENT NAME:			FORM COMPLETED BY:	TODAY'S DATE:
DATE OF BIRTH:	AGE:	SEX: (CIRCLE) Male Female	RELATIONSHIP TO PATIENT: (Circle) Father Mother Guardian	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____

Illnesses during pregnancy? No ☐ Yes ☐

Medications during pregnancy? No ☐ Yes ☐

Alcohol / Drug Abuse? No ☐ Yes ☐

Problems at birth? No ☐ Yes ☐

Describe: _____

Type of delivery? Vaginal ☐ C-Section ☐

Birth Weight: _____ Discharge Weight: _____

Did baby receive Hepatitis B vaccine? No ☐ Yes ☐

Date of Hepatitis B Immunization: _____

PSYCHOSOCIAL HISTORY

Who lives in household? _____

_____

How many people? _____

☐ Own? ☐ Rent? ☐ Shelter?

Who cares for child? _____

Are parents working? Mother Yes ☐ No ☐

Father Yes ☐ No ☐

Smokers at home? No ☐ Yes ☐ Who? _____

Primary Languages?_____

Other Language? _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Clotting Deficiency	Yes ☐	No ☐	_____
Easy Bruising	Yes ☐	No ☐	_____
Allergies (list all)_____	Yes ☐	No ☐	_____
_____			
Asthma	Yes ☐	No ☐	_____
Attention Deficit Disorder	Yes ☐	No ☐	_____
Easy Bleeding	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Eczema	Yes ☐	No ☐	_____
Heart Attack	Yes ☐	No ☐	_____
High Cholesterol	Yes ☐	No ☐	_____
Migraine	Yes ☐	No ☐	_____
Psychiatric Disorder	Yes ☐	No ☐	_____
Stroke	Yes ☐	No ☐	_____
Heart Disease	Yes ☐	No ☐	_____
SIDS	Yes ☐	No ☐	_____
High Blood Pressure	Yes ☐	No ☐	_____
Miscarriage	Yes ☐	No ☐	_____
Premature Birth	Yes ☐	No ☐	_____
Seizures	Yes ☐	No ☐	_____

Other (please list all) _____

_____

PATIENT MEDICAL HISTORY

Has your child ever had:

High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Birth Weight greater than 9 Pounds	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Allergies (list all) _____	Yes ☐	No ☐
_____		
Eczema	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐
Phototherapy	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Easy Bruising	Yes ☐	No ☐
Easy Bleeding	Yes ☐	No ☐
Birth Defects	Yes ☐	No ☐
Mental Retardation	Yes ☐	No ☐
Psychiatric Disorders	Yes ☐	No ☐
Premature	Yes ☐	No ☐
Migraine Headache	Yes ☐	No ☐
Stroke Syndrome	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐

Other (please list all) _____

_____