



## Aiea Pediatrics, LLC

Brent K. Tamamoto, M.D.

99-080 Kauhale Street, C-22, Aiea, HI 97601

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		

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		

#### LEGAL GURADIAN 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		

#### OTHER CONTACT INFORMATION: (Not including mother and father)

NAME OF CONTACT #1	RELATION TO PATIENT	HOME PHONE	CELL PHONE
NAME OF CONTACT #2	RELATION TO PATIENT	HOME PHONE	CELL PHONE
NAME OF CONTACT #3	RELATION TO PATIENT	HOME PHONE	CELL PHONE



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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

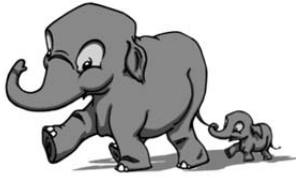
#### PLEASE READ THE FOLLOWING AND SIGN BELOW:

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 PERFORMANCE; (C) ANY WORKERS' COMPENSATION, NO-FAULT OR ADMINISTRATIVE PROCEEDING FOR THE PURPOSE OF EVALUATING MY MEDICAL CONDITION. THIS AUTHORIZATION 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**

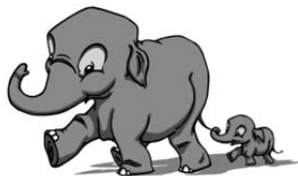
I also authorize the office of Brent K. Tamamoto, M.D. to also disclose and discuss any information regarding my medical care, including appointments and financial concerns, to any person listed below:

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 QUESTIONNAIRE

PATIENT NAME: _____			FORM COMPLETED BY: _____	TODAY'S DATE: _____
DATE OF BIRTH: _____	AGE: _____	SEX: (CIRCLE) Male <input type="checkbox"/> Female <input type="checkbox"/>	RELATIONSHIP TO PATIENT: (Circle) Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/>	
<b>PREGNANCY AND BIRTH HISTORY</b>			<b>PSYCHOSOCIAL HISTORY</b>	
Name of Hospital: _____			Who lives in household? _____	
Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/>			_____	
Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/>			How many people? _____	
Alcohol / Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/>			<input type="checkbox"/> Own? <input type="checkbox"/> Rent? <input type="checkbox"/> Shelter?	
Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/>			Who cares for child? _____	
Describe: _____			Are parents working? Mother Yes <input type="checkbox"/> No <input type="checkbox"/>	
Type of delivery? Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>			Father Yes <input type="checkbox"/> No <input type="checkbox"/>	
Birth Weight: _____ Discharge Weight: _____			Smokers at home? No <input type="checkbox"/> Yes <input type="checkbox"/> Who? _____	
Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/>			Primary Languages? _____	
Date of Hepatitis B Immunization: _____			Other Language? _____	
<b>FAMILY HISTORY</b>			<b>PATIENT MEDICAL HISTORY</b>	
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:			Has your child ever had:	
		Who?		
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies (list all) _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____			Birth Weight greater than 9 Pounds	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>
Attention Deficit Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Clotting Deficiency	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Allergies (list all) _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	
Eczema	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Eczema	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Phototherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Migraine Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Easy Bruising	Yes <input type="checkbox"/> No <input type="checkbox"/>
Premature Birth	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Easy Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>
Psychiatric Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Birth Defects	Yes <input type="checkbox"/> No <input type="checkbox"/>
Miscarriage	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Mental Retardation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Psychiatric Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
SIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Premature	Yes <input type="checkbox"/> No <input type="checkbox"/>
Easy Bruising	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Migraine Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>
Easy Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Stroke Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (please list all) _____			Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Other (please list all) _____	