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

PRENATAL REGISTRATION PACKET

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

EXPECTING MOTHER'S INFORMATION

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

EXPECTING FATHER'S 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			

NEWBORN INSURANCE INFORMATION

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:

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I ACKNOWLEDGE THAT I WAS GIVEN THE OPPORTUNITY TO READ AND REVIEW THE POLICIES AND PROCEDURES FOR AIEA PEDIATRICS LLC. I AGREE TO ABIDE BT THE POLICIES AND PROCEDURES. I MAY REQUEST A COPY OF THE POLICY AND PROCEDURES FROM A STAFF MEMBER AT ANY TIME.

NAME OF PATIENT'S PARENT/GUARDIAN	SIGNATURE:	DATE:

PRENATAL VISIT

Mother's name: _____ Father's Name: _____
Parents married? Y / N

Occupation: _____ Occupation: _____
Employer: _____ Employer: _____
Ethnicity: _____ Ethnicity: _____

Expecting Child's Name: _____
Due date: _____ Weeks Pregnant:_____ Obstetrician: _____
# of pregnancies: _____ # of live births: _____ # of abortions: _____ # of miscarriages: ____
Birth Hospital: Kapi'olani / Queens / Castle / Tripler Intended Birth Method: _____
Intended Feeding Method (circle one): Breast milk / Formula / Both
Circumcision? Y / N

How did you hear about our office? _____

PREGNANCY COURSE

How has your pregnancy gone? _____
Illnesses? _____
Medications? _____
Any smokers at home? Y / N Who? _____
Problems with previous pregnancies or deliveries? _____
Alcohol or Illicit Drugs? Y / N

FAMILY HISTORY
(Check all that apply and indicate relation to baby)

___High Blood Pressure:_____
___Diabetes:_____
___Infants larger than 9lbs at birth:_____
___High Cholesterol:_____
___Asthma:_____
___Eczema:_____
___Cancer:_____
___Seizure Disorder:_____
___Jaundice:_____
___Phototherapy:_____
___Easy bruising/Bleeding:_____
___Sudden Infant Death Syndrome (SIDS):_____
___Birth Defects:_____
___Mental Retardation:_____
___Psychiatric Disorder:_____
___Preterm Infant:_____
___Congenital Heart Disease:_____

ACKNOWLEDGMENT 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 Practices (the " Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. 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 a Home, Cellular, or Business number concerning any test results, appointment reminders, and/or regarding rescheduling appointments.

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:

NAME OF AUTHORIZED PERSON	**RELATIONSHIP TO PATIENT**
CONTACT NUMBER	**DATE**
SIGNATURE OF PARENT or LEGAL GUARDIAN	

NAME OF AUTHORIZED PERSON	**RELATIONSHIP TO PATIENT**
CONTACT NUMBER	**DATE**
SIGNATURE OF PARENT or LEGAL GUARDIAN	

NAME OF AUTHORIZED PERSON	**RELATIONSHIP TO PATIENT**
CONTACT NUMBER	**DATE**
SIGNATURE OF PARENT or LEGAL GUARDIAN	