NEW PATIENT INTAKE FORM RM#: ____ INS: _____ N: __

Name: _____ Age: _____ Date: _____
Primary Care Physician: _____
Referred By: _____
Preferred Pharmacy: _____

What is your chief symptom or problem? _____
Location of Pain/Problem: _____
What factors make the pain/problem worse? _____
_____
When did the pain/problem start (date)? _____

Please rate the severity or intensity of pain (circle number):

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

The pain is present: ❒ Constantly ❒ Intermittently ❒ At Night
The quality of pain is: ❒ Sharp ❒ Dull ❒ Burning ❒ Other
How did the symptoms/condition start? _____
_____
_____

Pain IMPROVES with _____ Pain WORSENS with _____
****

Systems Review – Please indicate "Yes" or No." If answer is "Yes," please describe the problem.

		YES	NO	TYPE
1.	Recent cold or flu?	____	____	_____
2.	Recent skin problems?	____	____	_____
3.	Recent eye/ear problem?	____	____	_____
4.	Recent nerve problem?	____	____	_____
5.	Recent depression/anxiety?	____	____	_____
6.	Recent respiratory problem?	____	____	_____
7.	Recent heart problem?	____	____	_____
8.	Recent intestinal problem?	____	____	_____
9.	Recent urinary problem?	____	____	_____
10.	Recent bleeding problems?	____	____	_____

ALLERGIES (please list what you are allergic to and the type of reaction): _____
_____

CURRENT MEDICATIONS

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

SUPPLEMENTS (e.g. St. John's Wort, Ginseng, Creatine): _____

Name: _____ Date: _____

PAST MEDICAL HISTORY – Please indicate "Yes" or "No"

CONDITION	YES	NO
Coronary Artery Disease		
High Blood Pressure		
Heart Attack		
Murmur		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Hyperlipidemia		
Stroke		
Seizure		
Kidney Failure		
Diabetes		
Thyroid Disease		

CONDITION	YES	NO
Gout		
Cancer		
If yes, Type:		
Asthma		
Tuberculosis		
Emphysema		
Hepatitis		
Ulcer		
GI Bleed		
Anemia		
Bleeding Disorder		
Deep Vein Thrombosis		

PAST SURGICAL HISTORY

Type of Surgery	Date of Surgery	Surgeon

PAST FAMILY HISTORY – Please indicate "Yes" or "No" if it pertains to an immediate family member only (e.g. parent, sibling, or grandparent)

CONDITION	YES	NO	RELATIONSHIP
Coronary Artery Disease			
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Thyroid Disease			
Cancer			
Hepatitis			
Anemia			
Bleeding Disorder			

SOCIAL HISTORY

Tobacco Use: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker
If Yes, Type: ☐ Cigarette ☐ Pipe ☐ Cigar ☐Other _____
# of Packs per day: _____ # of years smoking: _____

Alcohol Use: ☐ Yes ☐ No
If yes, # of Drinks per ☐ Day ☐ Week ☐ Month: _____

OTHER: Sports/Exercise: Type: _____ # Days/Week _____ Duration per Session: _____
High School: _____
College: _____
Occupation: _____
☐RIGHT-handed ☐LEFT-handed

For Office Use:
☐ IBU ☐ Nap ☐Cel☐ Norco-5☐ Norco-7 Ultram Medrol
PT: _____
Brace: _____
Disability Status: OW _____ Lt Duty _____
F/Up In: _____

IMUA Orthopedics, Sports & Health moving you forward

REGISTRATION FORM

☐ Elizabeth M. Ignacio, MD
☐ Nicole Y. Gesik, DO

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth

Address	City	State	Zip

Phone (Please ✓ Primary #)	☐ Home Phone	☐ Work Phone	☐ Cell Phone

Gender ☐ M ☐ F	SSN	Occupation	Employer

Marital Status	Work Status	School Status	Ethnicity	Race
☐ Single	☐ Full-Time	☐ Full-Time	☐ Hispanic/Latino	☐ American Indian or Alaska Native
☐ Married	☐ Part-Time	☐ Part-Time	☐ NON-Hispanic	☐ Asian
☐ Divorced	☐ N/A	☐ N/A	☐ Unknown/Refused	☐ Black/African American
☐ Widowed		School:	Preferred Language	☐ Native Hawaiian/Pacific Islander
☐ Other			☐ English	☐ White
			☐ Other	☐ Other

Please tell us how you heard about us:

☐ Doctor ☐ Friend/Relative ☐ Internet ☐ Television ☐ Other

Name of Referring Doctor or Friend/Relative	Primary Care Provider

INSURANCE INFORMATION

☐ Private Insurance ☐ Workers' Compensation ☐ No-Fault ☐ Third Party Liability

Condition we are treating you for today:	Date of Injury/Onset:	
If WC of NF Injury, Adjuster's Name:	Phone:	Fax:

Primary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:

Policy or Claim #:	Pt's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:

Policy or Claim #:	Pt's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Tertiary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:

Policy or Claim #:	Pt's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

RESPONSIBLE PARTY INFORMATION (Complete ONLY if different from patient)

Last Name	First Name	MI	Date of Birth

Address	City	State	Zip

Phone (Please ✓ Primary #)	☐ Home Phone	☐ Work Phone	☐ Cell Phone

Gender ☐ M ☐ F	SSN	Occupation	Employer

If patient is a minor, person(s) who may authorize treatment: _____

Relationship to patient: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone (Please ✓ Primary #)	☐ Home Phone	☐ Work Phone	☐ Cell Phone

RELEASE OF INFORMATION

I authorize the release of confidential medical information to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

APPOINTMENT REMINDERS

I'd like receive appointment reminders by: (you may select both options)

☐ Text Phone #: _____

☐ E-Mail Email Address: _____

I would like to receive the IMUA Orthopedics, Sports & Health email newsletter: ☐ Yes ☐ No, thank you

☐ To email address listed above ☐ Alternate email: _____

ACKNOWLEDGEMENTS & CONSENTS

I verify that the information provided above is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to ***IMUA Orthopedics, Sports & Health*** *for any services furnished to me.*

I authorize IMUA Orthopedics, Sports & Health, LLC to disclose/request my health information, including copies of records as necessry, to/from:

1. *Any health insurance plan, company, or billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagositc facilities, labs, radiology/imaging, outpatient facilities and hospitals, and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for IMUA Orthopedics, Sports & Health to evaluate clinical performance.*
4. *Any workers' compensation, no-fault, or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by IMUA Orthopedics, Sports & Health, LLC as detailed above.

Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I hereby give my consent to IMUA Orthopedics, Sports & Health to use or disclose, for purposes of carrying out treatment, payment, or healthcare operations, all protected health information contained in the health record of _____ (print patient's name). I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to disclose my health information. Written revocation of consent must be sent to this facility.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was made aware of IMUA Orthopedics, Sports & Health's Privacy Policy and a copy was available for my review.

Acknowledgement of Receipt of Office and Financial Policies:

I acknowledge that I have reviewed and received a copy of the Office and Financial Policies of IMUA Orthopedics, Sports, & Health, LLC

My signature below indicates my full understanding and consent to the above-described policies

_____ _____

Signature Date

_____ _____

Print Name Relationship to Patient

Welcome to IMUA Orthopedics, Sports & Health! We are glad that you have chosen us to take care of your health care needs, and we look forward to partnering with you to realize your health care goals. In order to keep you informed of our Office and Financial Policies, we ask that you read and sign our acknowledgement prior to any treatment. Please speak with us if you have any questions.

OFFICE POLICIES

APPOINTMENTS – The office hours for each physician will vary, but every effort will be made to accommodate the date and time desired. Office visits are by appointment only. While every effort will be made to keep your wait time to a minimum, emergencies do occur and will be given priority. We will attempt to contact you as soon as possible to provide the option of rescheduling your appointment

CANCELLED APPOINTMENTS / NO SHOWS - If it is necessary to cancel your appointment, we kindly ask that you give us at least 24 hours notice so that we may accommodate other patients in need of our services. Please note that a $30.00 Cancellation/No Show fee may be billed to you (which is not payable by your insurance) for any missed appointments if proper notification has not been received by our office. Patients arriving more than 15 minutes after their scheduled appointment will be considered a "No Show." Repeated "No Shows" may result in a temporary suspension of services.

AFTER HOURS EMERGENCIES – If you are having a medical emergency, please call 911 immediately and go to your nearest emergency room. Our physicians can also be reached after hours through the Physicians Exchange at 524-2575.

PRESCRIPTION REFILLS – Please call our office during normal business hours to obtain medication refills. This will allow your physician to consult your medical record and make the best decision regarding your care. Prescriptions will be called in within 48 hours of request. Refills will not be handled after hours, and will be only considered under emergency circumstances.

MEDICAL FORMS COMPLETION - A $10.00 - $25.00 fee will be charged for completion of insurance forms such as TDI, Life Insurance, or Flexible Spending forms (the charge is based upon the number of pages and complexity of the information requested). Payment is required at the time the forms are picked up.

REQUEST FOR COPIES OF MEDICAL RECORDS - If you are requesting a copy of your medical records for yourself or a third party, we require a signed authorization by the patient or their Legal Representative. This form may be faxed in to (808) 521-8127. Please allow ten (10) days' notice. There may be a fee charged for this, and payment in full is required before the records can be released.

FINANCIAL POLICIES

IMUA Orthopedics, Sports & Health participates with most insurance plans. We will gladly file claims on your behalf, however, payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party. You will be required to complete an Injury/Illness form stating that your injury is NOT the result of a third party's liability.

HMO / MANAGED CARE PLAN REFERRALS - Some insurance plans require that you obtain a referral from your primary care provider in order for your visit to be covered. Failure to obtain the necessary referrals may lead to your visit being denied, and as a result, your having to be responsible for the entire balance. If you arrive for your appointment without a referral, we reserve the right to reschedule your appointment.

WORKERS' COMPENSATION / AUTOMOBILE ACCIDENT / THIRD PARTY LIABILITY – If your injury is a result of a work-related injury, automobile accident, or due to another party's negligence, we must have approval from your adjuster prior to your visit. Failure to properly report the injury to your employer/insurance carrier may result in your claim being denied and the balance being your responsibility.

HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

INJURY/ILLNESS REPORT FORM

SECTION I: GENERAL INFORMATION
PLEASE COMPLETE THIS SECTION

a) Name of HMSA member or dependent injured or ill: _____

b) Date of injury/illness: _____

c) Where did this occur? ☐ Work ☐ Home
☐ Other (please explain) _____

d) Please describe how your accident happened: _____

e) Diagnosis or brief description of the type of injury/illness (example: broken ankle)

f) Your phone number: _____Work _____Home

g) Have you hired or plan to hire an attorney to represent you in connection with this injury or illness?
☐ Yes ☐ No. If "YES," please indicate:
Name of your attorney: _____
Address: _____ Phone: _____

SECTION II: WAS YOUR ACCIDENT RELATED TO YOUR WORK? ☐ YES ☐ NO
PLEASE COMPLETE THIS SECTION IF YOU ANSWERED "YES" ABOVE

a) Have you filed for Workers' Compensation? ☐ Yes ☐ No
If "NO," please explain: _____
If "YES," please answer the following questions.

b) What is the status of your Workers" Compensation claim? _____

c) Who is your employer? _____Phone: _____
What insurance company covers your Workers' Compensation?

Note: If your case has been settled, please submit a copy of the settlement document.

SECTION III: DID YOUR INJURY INVOLVE A MOTOR VEHICLE? ☐ YES ☐ NO
PLEASE COMPLETE THIS SECTION IF YOU ANSWERED "YES" ABOVE

a) Please check one: Were you a ☐ passenger? ☐ driver? ☐ pedestrian?

b) If you were a **passenger** or a **driver,** please indicate:
The owner of the vehicle: _____
Address: _____Phone: _____
The name of the company which insured the vehicle you were in: _____

c) If you were a **pedestrian,** please indicate:
The name of the owner of the vehicle which struck you: _____
Address: _____Phone: _____
The name of the insurance company which insured that vehicle: _____

d) Are no-fault benefits available for this accident? ☐ Yes. ☐ No.
If "YES," please indicate your policy limit: $_____.
If "NO", please explain: _____

(continued on next page)

INJURY/ILLNESS REPORT FORM
PAGE TWO

e) The name of your motor vehicle insurance carrier: _____
If none, the name of the motor vehicle insurance carrier of anyone in your household?
_____

SECTION IV: DO YOU BELIEVE ANOTHER PERSON(S) IS OR MAY BE RESPONSIBLE FOR YOUR ACCIDENT OR ILLNESS? ☐ YES ☐ NO PLEASE COMPLETE THIS SECTION IF YOU ANSWERED "YES" ABOVE

a) Name and address of person(s) you believe could be responsible:
Name: _____
Address: _____
b) Date on which you discovered that the person(s) could be responsible: _____
c) Have you made any written claim or demand, or initiated any legal action, against that person(s) in connection with your accident or illness? ☐ Yes. ☐ No.
If "NO," please explain: _____
If "YES," please answer the following questions.
d) What is the status of your claim, demand, and/or action? _____
Please send us a copy of all claims, demands, and/or complaints that you have made or that have been made on your behalf, regarding your accident or illness.
e) Have you received any money from another source as a result of your accident?
☐ Yes. ☐ No.
If "YES," please give us the name of the source: _____
f) If there was a settlement, what was the date of the settlement? _____
What was the settlement amount? _____
What is the name of the person or carrier from which you received this money?
_____
Please send us a copy of your settlement document.
g) If you will not be pursuing any third party claim against the other party who may be at fault, please explain why: _____
_____

PLEASE READ THE FOLLOWING CAREFULLY

By signing below, I certify that the above information is true and correct to the best of my knowledge and that I have received a copy of HMSA's Third Party Liability and Motor Vehicle Insurance Rules.

_____ _____
Name of Member or Dependent (PLEASE PRINT) Signature of Member or Dependent

_____ _____
HMSA Membership Number Date

Any alterations or changes you make to this Agreement will render the Agreement void and invalid.