HAWAIIAN ISLANDS
DERMATOLOGY

Demographics

PATIENT INFORMATION		
First Name	Last Name	Preferred Name
Date of Birth	SS # IF YOU ARE A VETERAN	Gender M / F
Address	City	State ZIP
Primary Phone #	Type of Phone	Additional Phone #
Email		
Primary Care Doctor/Referring Provider		PCP Phone #
EMERGENCY CONTACT		
Full Name	Phone #	Relationship to Patient
INSURANCE INFORMATION		
Primary Insurance Type	Subscriber Name	Relationship to Patient
Subscriber Date of Birth	Subscriber Social Security #	Gender
Secondary Insurance Type	Subscriber Name	Relationship to Patient
Subscriber Date of Birth	Subscriber Social Security #	Gender
Tricare Patients: Sponsor Benefits #		
GUARANTOR INFORMATION (Responsible for billing)		
Guarantor Name (If under 18)	Subscriber Name	Relationship to Patient
Phone Number	Address	

How did you hear about us? ❒Yelp ❒ Google ❒Family/Friend ❒Instagram/Facebook ❒Other _____

Signature _____ **Date**_____

1051 Keolu Dr. Suite 107
Kailua, Hawai'i 96734

Phone (808) 263-3233
Fax (808) 263-3220

Hidermatology.com
info@kailuaderm.com

HAWAIIAN ISLANDS
DERMATOLOGY

Medical History

PAST MEDICAL HISTORY (Circle all that apply)		
Anxiety	Arthritis	Artificial Heart Valve
Artificial Joint	Asthma	Cancer
Diabetes	Depression	Hepatitis, Type _____
High Blood Pressure	High Cholesterol	HIV/AIDs
Immunosuppression	Organ Transplant	Pacemaker/Defibrillator
Pregnant/Nursing	Radiation Treatment/History	Seizures
Thyroid: Hyper/Hypo	**NONE**	
Other Health Conditions:		
Surgical History		

SKIN HISTORY (Circle all that apply)		
Actinic Keratosis	Basal Cell Skin Cancer	Blistering Sunburns
Cold Sores/Oral Herpes	Eczema	Fainting w/Procedures
Hay Fever	Keloid Scarring	Melanoma
Precancerous Moles	Psoriasis	Reaction to local anesthetic
Squamous Cell Skin Cancer	**NONE**	
Other Skin Conditions:		

Do you wear sunscreen?	Tanning salon use?	Family history of melanoma?
❒ Yes, SPF _____ ❒No	❒ Yes ❒ No ❒ Previous	❒ Yes, _____ ❒ No

Medications (prescriptions, supplements, vitamins)

Allergies

Smoking Status ❒ Never Smoker ❒ Current Smoker ❒Former Smoker

Patients 65+

Have you had your pneumonia vaccine?
❒ Yes ❒ No

Have you established an advanced care plan?
❒ Yes ❒ No

Signature _____ **Date**_____

1051 Keolu Dr. Suite 107
Kailua, Hawai'i 96734

Phone (808) 263-3233
Fax (808) 263-3220

Hidermatology.com
info@kailuaderm.com

HAWAIIAN ISLANDS
DERMATOLOGY

Medical History

PAST MEDICAL HISTORY		
Do you <u>currently</u> have any of the following? Please check yes or no.		
	YES	NO
Problems with bleeding		
Problems with scarring		
Problems with healing		
Rash		
Immunosuppression		
Unintentional weight loss		
Night sweats		
Fever of chills		
Sore throat		
Shortness of breath		
Wheezing		
Cough		
Chest pain		
Seizures		
Headaches		
Neck stiffness		
Muscle weakness		
Joint aches		
Blurry vision		
Bloody urine/stool		
Abdominal pain		
On blood thinners		
Allergy to adhesive		
Allergy to lidocaine		
Rapid heart beat with epinephrine		
Allergy to topical antibiotic ointments		
PHARMACY		
Preferred pharmacy (name and location)		

Signature _____ **Date**_____

1051 Keolu Dr. Suite 107
Kailua, Hawai'i 96734

Phone (808) 263-3233
Fax (808) 263-3220

Hidermatology.com
info@kailuaderm.com

HAWAIIAN ISLANDS
DERMATOLOGY

Financial Office Policy and Consents

PATIENT RESPONSIBILITY FOR PAYMENT

Patient Name

Basic Policy: Payment for service is due in full at the time the services are provided. For patients with insurance: Co payments are due at the time of service.

Missed Appointments: I understand that if my appointment is canceled without a 24 hour notice or if it is deemed a no show I will be charged a $50.00 fee. For surgeries we require 72 hrs notice to cancel/ reschedule and a $100.00 fee will be charges for all no shows/ late cancellations. I also understand that repeated occurrences may result in release from this practice.

Returned Check Policy: There will be a $40.00 fee for a check returned by the bank for any reason.

Account Payments: I understand that any balance due that is not paid within 60 days may be turned over to a collection agency and may increase for any recovery fees incurred by his process.

Authorization and Release: I request that payment of authorized insurance benefits be made on my behalf to Hawaiian Islands Dermatology, LLC for any services rendered to me. I hereby agree to pay any and all charges that are not covered by insurance. I authorize the release of my medical information to my insurance company or Worker's Compensation carrier that is necessary to determine benefits or the benefits payable for related services.

Privacy Practices Acknowledgment: I have received and reviewed the private practices.

Signature _____ **Date**_____

MEDICAL RELEASE (optional)

Information may be released to the following family member/friend/etc:

Name	Relationship to Patient	Phone number

Community Exchange: I authorize Hawaiian Islands Dermatology, LLC to use any means of electronic transmission to any Healthcare Professional, Hospital or Healthcare Facility to exchange my Protected Health information.

Medication History: I authorize Hawaiian Islands Dermatology, LLC to obtain my Medical History from our clearinghouse. The Medication History will include Medications prescribed by all Healthcare Providers.

Patient Referral: I authorize Hawaiian Islands Dermatology, LLC to provide an electronic health record for each transition of care to another setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care. Home health, and rehabilitation facility) or provider of care or refer their patient to another provider.

Your signature below signifies your understanding and willingness to comply with the above policy and consent to the community exchange, immunization registry, medication history, and patient referral as described above.

Signature _____ **Date**_____

1051 Keolu Dr. Suite 107
Kailua, Hawai'i 96734

Phone (808) 263-3233
Fax (808) 263-3220

Hidermatology.com
info@kailuaderm.com

HAWAIIAN ISLANDS
DERMATOLOGY

Hawaii Privacy of Health Care Information on Law Notice or Privacy Practices

Privacy Practices

Patient Name

This notice describes how your medical info may be used and disclosed.

Use and disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways without your signed authorization.

- Continuation of care by a specialist or another doctor
- Release of information to your health plan for payment
- Payment to physicians and hospitals who provide you with health care services
- When release is required by law, including in judicial settings and to health oversight agencies and law enforcement In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties to organ, tissue and other donation organizations
- To contact you about appointment reminders, treatment alternatives and other health related benefits and services
- All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us

Your rights: You have the following rights concerning your PHI:
- To inspect and request copies of your medical records or appeal any denial of your request for inspection or copying
- To request that your health care provider append information to your medical record
- To receive correspondence of confidential information by alternate means or location
- To receive an accounting of the disclosures by us of your PHI
- To get updates or reissue of this notice, at your request
- To complain to us or the U.S. Dept. of Health & Human Services if you feel your privacy rights have been violated

How you can inspect, obtain copies of and/or amend your medical record:
- If you wish to obtain copies of your medical records, send a written request to this office and you will be provided a full copy within 30 days
- If you wish to attach information to improve the accuracy of completeness of your medical record, submit your request in writing to this office and this office and this information will be attached to your record. None of the digital records may be destroyed or erased.

We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Signature _____ **Date**_____

CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name

I consent for the medical photographs to be made of me or my child (or person whom I am legal guardian). I understand that the information may be used for my medical record only. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact Hawaiian Islands Dermatology, LLC.

Signature _____ **Date**_____