Waimea Urgent Care- Lorraine Sonoda-Fogel, MD

65-1230 Mamalahoa Hwy #A10, Kamuela Hi 96743

PATIENT REGISTRATION - CONFIDENTIAL

Personal Information

Last Name: ________________________ **First Name:** ____________________ **M.I.** ________

Home #: _____ - _____- _____ **Cell #:** ______ - _____ - _____ **SSN:**_____-_____-__________

Mailing Address: ____________________________ **City:** ____________ **Zip code:** _________

Street Address: ____________________________ **City:** ____________ **Zip code:** _________

Date of Birth: ____ /____ /____ **Age:** ________ **Drivers License #:** _______________

Sex: Male / Female **Marital Status:** Single / Married / Divorced / Partner / Minor

Employer: __________________________ **Work#:** _____ - _____ - ________

Email: ______________________ **Referred By:** ____________________

Emergency Contact: ________________________ **Phone:** ______ - _____ - _________

Primary Care Physician: ______________________ **Phone:** ______ - _____ - _________

Address: ______________________________ **City:** ________ **Zip code:** _________

Insurance Information:

Primary

Insurance Company: ______________ **Subscriber's Name:** ____________________

Subscriber's DOB: ______________ **Policy Number:** ____________________

Subscriber's Sex: Male / Female **Relationship to Patient:** ________________

Secondary

Insurance Company: ______________ **Subscriber's Name:** ____________________

Subscriber's DOB: ______________ **Policy Number:** ____________________

Subscriber's Sex: Male / Female **Relationship to Patient:** ________________

Responsible Party Information

Name: __________________________ **Address:** ________________________

City: __________________ **State:** _______ **Zip code:** ________________

Phone #: _____ - _____- __________ (If different from above) ______ **Check if info above is same as Responsible Party**

I hereby authorize Lorraine Sonoda-Fogel, M.D., to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services referred to myself or my dependants. I understand that I am responsible for any amounts not covered by insurance.

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient / Legal Guardian ______________________________ **Date:** ___________

WAIMEA URGENT CARE 65-1230 Mamalahoa Hwy., A10 Kamuela, HI 96743 (808)885-0660

MEDICAL HISTORY

Please answer **ALL** questions 1-10 below : ↓↓↓↓

1. **Reason For Visit** (List symptoms &/ or limb, body part affected, etc)

2. **When did your symptoms start?**: (Date, Weeks, Days)

3. **INJURIES: HOW and WHERE did it happen?** (Work, Home, Other)

4. **(IF YOU LIVE ON ISLAND) Who is your Primary Care Physician?**

5. **List ALL MEDICATIONS you are currently taking** (Including over the counter supplements, creams, ointments, or any type of drop solutions)

6. **ALLERGIES** (to Medications or Shellfish only)

7. **List ALL MEDICAL CONDITIONS** (i.e. Hypertension, Diabetes, Cancer, Asthma, etc.) or Major Surgeries. (i.e. Organs removed, Joint Replacement, etc.)

8. **FEMALES :** When was your last menstrual period? : (If no periods, List the reason)

9. **Date of last Tetanus Shot:**

10. **Alcohol?** No____ Occasionally___ Daily (How Many?)_____

Smoker? Yes___ Quantity Per Day? ____

No___ Quit? (How Long Ago?) ______

Name: ____ **Date:**___________ **DOB:**__________

Signature of Patient OR Responsible Party : ____

Adopted January 2006

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of the Notice Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (808) 885-0660 or by requesting one at the Waimea Urgent Care office.

______________________ ______________________

Date (Signature*)

____

(Print or Type Name)

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

______________________ ______________________

Date (Signature)

____

(Relationship)

Waimea Urgent Care

Pre-Visit Screening Questionnaire

(Please fill out every question, do not leave any blank)

1. Have you or a member of your household had any of the following symptoms in the last 21 days:
(Please circle the appropriate symptoms)

A. Sore Throat
B. Cough
C. Chills
D. Body Aches
E. Shortness of Breath
F. Loss of Smell
G. Loss of Taste
H. Fever/Temperature greater than 100 degrees Fahrenheit

2. Have you or a member of your household been tested for COVID-19? If Yes, please write the date of the test, the results, is person currently in quarantine and what type of symptoms occurred?

3.Have you or a member in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facilities in the past 30 days? If Yes, please state the name of the facility, location, and reason for visit as well as date of service.

4. Have you or a member in your household traveled anywhere in the past 30 days? This includes interisland travel, anywhere in or outside of the U.S and cruise ships.
(If Yes, please list city, state, country, name of cruise ship and dates)

5. Are you or a member of your household Healthcare Providers, Workers or Emergency Responders?
(If Yes, what type of work does the person do, and are they still working)

6. Have you or a member in your household cared for an individual who is in quarantine or is a presumptive positive or has previously tested positive for COVID-19 ?
(If Yes, please state the status of person cared for, when the care occurred, and what type of care was given)

7. Do you have any reason to believe that you or a member of your household has been exposed to or acquired COVID-19? (If Yes, Please provide reason behind the belief of potential exposure and any signs that the person may have had the virus)

8. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? (If Yes, please provide information about when contact occurred, and how long you were in contact)

By signing this document, you acknowledge all information provided is correct and true and if for any reason you should falsify the answers given, and would result in the spread of the COVID-19 virus, you are obligated to contact Waimea Urgent Care immediately to alert them or be met with legal action upon their discretion.

Please note that our office requires that all patients/visitors follow CDC guidelines regarding the use of Face coverings to prevent the spread of COVID-19 as you can have the virus without having symptoms. For that reason , it will be mandatory to use a face covering in order to be treated at Waimea Urgent Care. Children under the age of 2 will not be required to wear a facial covering.

Waimea Urgent Care reserves the right to refuse service.

Print name of patient: ____________________________

Signature of patient/ Legal guardian: ____________________________

Date: ________________