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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Aiea, Hawaii96701

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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

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

PATIENT REFERRED BY:

NAMES OF IMMEDIATE FAMILY MEMBERS WHO ARE PATIENT'S OF DR. TAMAMOTO:

NAME:	DATE OF BIRTH	RELATIONSHIP TO PATIENT

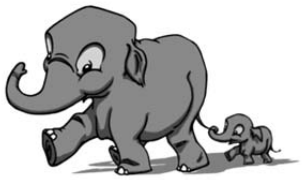
PLEASE READ THE FOLLOWING AND SIGN BELOW:

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

Aiea Pediatrics, LLC

Brent K. Tamamoto, M.D.

99-080 Kauhale Street, C-22

Aiea, Hawaii 96701

(808) 487-1600

Changes of Insurance and No Show Policy and Procedures

It is our intention to provide your children the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review the Change of Insurance and No Show policies that affect the way services are provided.

Due to changes within HMSA's new policies for coverage of insurance plans and additional requirements for payments of services, it has become necessary to implement an office policy change to ensure that we can continue providing the best quality of care for all of our patients. HMSA is requiring more paperwork and information to be submitted for payment of services, which has resulted in our time shifting from patient care to filling out more forms. HMSA is also not covering any patients who have not been assigned to Dr. Brent Tamamoto until they have been notified by the subscriber of the insurance plan and our office has manually added them into our panel via a secure website.

As a result of the above, we have implemented the following new Policies and Procedures.

1) **Change in Insurance Coverage**
   It is the parent's or guarantor's responsibility to inform our office of any changes of insurance, which include an addition and/or a termination of insurance.

   a) **Please call our office at (808) 487-1600 as soon as you know of changes to your child's insurance so that we can update our records.**

   b) **Call your insurance company and inform them that you have selected Dr. Brent Tamamoto as your Primary Care Physician.**

   A $25 per month administration fee may be added to a patient's account for any months there is a gap in coverage for the additional administrative expenses and time that include but are not limited to following up with the necessary insurance companies, completing and filing required paperwork, and any additional work necessary to up-date the patient's insurance during the gap of coverage period.

2) **Aiea Pediatrics LLC Appointment Cancellation and No Show Policy**
In order to better serve all our patients and families we are asking that you give us at least 24 hours notice should you need to reschedule or cancel your child's appointment, especially a well child visit. This will allow other families access to that appointment slot.

a) **Patients/families who fail to keep or cancel their scheduled appointment without providing 24 hours prior notice will be charged $25.00 for the first missed appointment and will increase by $10.00 for every instance this happens thereafter. Appointments cancelled the same day may also be subject to a $25.00 fee.** This fee will be owed by the patient at their next scheduled visit. We understand that situations come up that are out of our control and we are happy to work with you, if you communicate with us. However, this issue raises a financial loss and costs the practice to maintain these missed scheduled times. We need to work together to ensure that we can continue caring for your child(ren)s health for many years.

In the event you are counted as a "No Show" to an appointment, we will discuss the missed appointment with you at the next visit, reminding you of our policy. **If there are two or more "No Show" appointments, your relationship with our practice may be terminated. Once terminated, we will send you a final bill for any outstanding balances**.

3) **Contact Person.**
The person to contact for further information or comments concerning our privacy practices is:

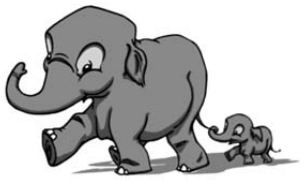
Dr. Brent Tamamoto
Aiea Pediatrics LLC
(808) 487-1600
contact@aieapediatrics.com

I have read and agree to the above Policies and Procedures.

_____ _____
Patient's Name(s) Relationship to patient

_____ _____
Signature Date

_____
Printed Name



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MEDICAL / FAMILY HISTORY QUESTIONAIRE

PATIENT NAME:			FORM COMPLETED BY:	TODAY'S DATE:
DATE OF BIRTH:	AGE:	SEX: (CIRCLE) Male Female	RELATIONSHIP TO PATIENT: (Circle) Father Mother Guardian	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____

Illnesses during pregnancy? No ☐ Yes ☐

Medications during pregnancy? No ☐ Yes ☐

Alcohol / Drug Abuse? No ☐ Yes ☐

Problems at birth? No ☐ Yes ☐

Describe: _____

Type of delivery? Vaginal ☐ C-Section ☐

Birth Weight: _____ Discharge Weight: _____

Did baby receive Hepatitis B vaccine? No ☐ Yes ☐

Date of Hepatitis B Immunization: _____

PSYCHOSOCIAL HISTORY

Who lives in household? _____

_____

How many people? _____

☐ Own? ☐ Rent? ☐ Shelter?

Who cares for child? _____

Are parents working? Mother Yes ☐ No ☐

Father Yes ☐ No ☐

Smokers at home? No ☐ Yes ☐ Who? _____

Primary Languages?_____

Other Language? _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Heart Attack	Yes ☐	No ☐	_____
Allergies (list all)_____	Yes ☐	No ☐	_____
_____			
Asthma	Yes ☐	No ☐	_____
Attention Deficit Disorder	Yes ☐	No ☐	_____
Clotting Deficiency	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Eczema	Yes ☐	No ☐	_____
Seizures	Yes ☐	No ☐	_____
Heart Disease	Yes ☐	No ☐	_____
High Cholesterol	Yes ☐	No ☐	_____
High Blood Pressure	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____
Migraine Headaches	Yes ☐	No ☐	_____
Premature Birth	Yes ☐	No ☐	_____
Psychiatric Disorders	Yes ☐	No ☐	_____
Miscarriage	Yes ☐	No ☐	_____
Stroke Syndrome	Yes ☐	No ☐	_____
SIDS	Yes ☐	No ☐	_____
Easy Bruising	Yes ☐	No ☐	_____
Easy Bleeding	Yes ☐	No ☐	_____

Other (please list all) _____

PATIENT MEDICAL HISTORY

Has your child ever had:

High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Birth Weight greater than 9 Pounds	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Allergies (list all) _____	Yes ☐	No ☐
_____		
Eczema	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐
Phototherapy	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Easy Bruising	Yes ☐	No ☐
Easy Bleeding	Yes ☐	No ☐
Birth Defects	Yes ☐	No ☐
Mental Retardation	Yes ☐	No ☐
Psychiatric Disorders	Yes ☐	No ☐
Premature	Yes ☐	No ☐
Migraine Headache	Yes ☐	No ☐
Stroke Syndrome	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐

Other (please list all) _____

Child Proxy Access Request Form

MyChart by Hawai'i Pacific Health

PLEASE PRINT THE CHILD'S INFORMATION IN THIS BOX (patient label ok)

Child's Name *(last, first, middle initial)*:_____ Sex: _____

Date of Birth: ____ / ____ / _____ Medical Record Number (MRN):_____
Month Day Year

I understand that Hawai'i Pacific Health and its affiliate health care providers (collectively, "HPH") share an integrated electronic medical record. I also understand the general policy of HPH is not to disclose my child's Protected Health Information (PHI) to others without my permission unless they are directly involved in my child's care, or as permitted or required by law. To sign up for access to your child's MyChart by Hawai'i Pacific Health record ("MyChart"), please complete this form and return it to your child's provider or FAX to Straub's Health Information Management Department at 808-522-3207.

Please note: You must have your own MyChart account to access your child's MyChart record. Completing this form will allow us to create a MyChart record for you if you do not already have one.

Please call Straub's Health Information Management Department at 808-522-4285 if you need assistance with completing this form.

INFORMATION OF PARENT/GUARDIAN REQUESTING PROXY ACCESS (all fields are required - please print clearly)

Name *(last, first, middle initial)*: _____

Date of Birth:_____ Relationship to Patient: _____

Street address: _____ City: _____ State: _____ Zip:_____

Phone#: _____ Email address: _____

MYCHART BY HAWAI'I PACIFIC HEALTH ACCOUNT TERMS AND AGREEMENT. I understand that:

- MyChart is provided as a secure online source of confidential health information.
- MyChart record contains select, limited medical information from my child's health record and it is not the complete contents of the health record - a copy of the patient's health record may be requested by contacting the Health Information Management Department.
- If I share my username and password with another person, that person may be able to view my and my child's health information.
- It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe confidentiality may have been compromised in any way.
- It is my responsibility to ensure that my email address is current at all times. If my email address is not current I will not receive important MyChart messages from HPH.
- My activities within my MyChart account may be tracked electronically and entries I make may become part of the health record.
- MyChart proxy access is provided as a convenience to patients. HPH has the right to end access at any time, for any reason.
- Use of my MyChart account is voluntary. I am not required to use my account.
- Child proxy access will be limited as described below. These age range limitations do not affect any legal right I may have to access my child's record by other means. I can request a copy of my child's record by contacting the Health Information Management Department.
  - o Age 0-13: you will be granted full access to your child's MyChart record.
  - o Age 14-17: you will be granted partial access to your child's MyChart record (appointment scheduling, immunizations).
  - o Age 18: you will no longer have access to your child's MyChart record.

My Responsibility: I understand it is my responsibility to update this information as needed.

Approval Signature of Parent and/or Legal Guardian: _____

Print Name: _____ **Date:**_____

If signed by someone other than the parent or legal guardian, please describe your legal authority to act on behalf of the Patient:

_____