



Jenny Horita Welham, MD
 1401 S. Beretania St, Ste 370
 Honolulu, HI 96814
 Office: (808) 944-1844
 Fax: (808) 947-9987

PATIENT REGISTRATION FORM

Patient Name (Last, First, M.I.):	DOB:	Male <input type="checkbox"/> Female
Mother Name (Last, First, M.I.):	DOB:	Occupation:
Address:	City/State:	Zipcode:
Employer:		Mom Mobile #:
Employer:		Work #:
Email:		Home #:
Father Name (Last, First, M.I.):	DOB:	Occupation:
Address: <input type="checkbox"/> same as above	City/State:	Zipcode:
Employer:		Dad Mobile #:
Employer:		Work #:
Email:		Home #:
Emergency Contact/Relationship:		Phone #:
Any smokers? Yes No Primary Language(s) Spoken at Home: English Other:		
Ethnicity: Asian Caucasian Hispanic American Indian African American Pacific Islander Other:		
<i>Please Provide Your Insurance Card And Identification To Our Front Office Staff To Make A Copy For Our Records</i>		
Your Primary Insurance:	Subscriber Name:	
Secondary Insurance:	Subscriber Name:	
SSN of sponsor if you have Tricare:		

Siblings Names (Last, First, M.I.)	Birth Date		
		Male	Female
		Male	Female
		Male	Female
		Male	Female

Family History: (Please circle Y or N and explain if indicated)

Allergies/Asthma	Y	N	If Yes, please explain _____
Diabetes	Y	N	If Yes, please explain _____
Hypertension (HBP)	Y	N	If Yes, please explain _____
Seizures	Y	N	If Yes, please explain _____
Cardiovascular Disease	Y	N	If Yes, please explain _____
Autoimmune Conditions	Y	N	If Yes, please explain _____
Other	Y	N	If Yes, please explain _____

PATIENT or Parent/Guardian Signature (for those under 18 years of age)

 Date



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PAST MEDICAL HISTORY

BIRTH HISTORY			
Birthplace:	Birth Weight:		
Any problems with pregnancy or delivery:			
Full Term Birth? Y N If No, how many weeks at birth? _____			
Type of Delivery (Please Select One): Vaginal C-Section			
NICU: Y N If Yes, Reason for NICU Hospitalization:			
Was your baby breastfed formula fed, or both?		If breastfed, how long? _____ Vitamin D? <input type="checkbox"/> No <input type="checkbox"/> Yes	
PATIENT MEDICAL HISTORY			
ALLERGIES: NO <input type="checkbox"/> YES; please list below:			
DOES YOUR CHILD TAKE Fluoride Vitamins Supplements Special diet Other Treatments? If yes, please explain:			
HAS YOUR CHILD HAD ANY SURGERIES? No <input type="checkbox"/> YES; please list year and type of surgery below:			
HAS YOUR CHILD HAD ANY HOSPITALIZATIONS/ILLNESSES/INJURIES? No <input type="checkbox"/> YES If yes, please list year and explain below:			
HAS YOUR CHILD SEEN ANY SPECIALISTS? <input type="checkbox"/> No <input type="checkbox"/> YES; please list doctor(s), therapists and reason for specialty care:			
PLEASE CHECK BELOW if YOUR CHILD has/had any of the following?			
ADD/ADHD	Eczema	High Cholesterol	Seizures/epilepsy
<input type="checkbox"/> Allergy(eye, nose, skin)	Depression/Anxiety	Immune Problems	Skin problem
Anemia	Developmental Delay	Gastroesophageal reflux	Snoring
Asthma	Food allergies	Learning Disability	Speech Difficulty
Autoimmune condition	Frequent ear infections	Migraines	+TB test
Bleeding Problem	Hearing Problems	Obesity	Thyroid problem
<input type="checkbox"/> Constipation/Diarrhea	Heart Condition	Frequent Infections	UTI/Kidney Infection
Other:			



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ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY POLICIES

To better serve our patients, we have revised our policy notice effective October 1, 2017.

PRIVACY POLICIES ACKNOWLEDGEMENT OF RECEIPT (HIPPA)

I have read a copy of Jenny Welham, MD LLC's Notice of Privacy Policies with the effective date of July 1, 2016. If you would like a copy of the Notice of Privacy Policies, you may ask the receptionist at the front desk.

INFORMATION UPDATE

Upon checking in, please inform office staff of any changes to your information (address, phone numbers, insurance, etc.) Any charges incurred to your account will be your responsibility if you do not inform us of any changes.

VACCINE ADMINISTRATION

I have been provided a copy of the appropriate Vaccine Information Statement (V.I.S) prepared by the Center for Disease Control, and have read, or have explained to me, information about the diseases and the vaccine cited. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this vaccine, and ask that it be given to the person named below (for whom I am authorized to make this request).

FORMS AND MEDICATION REFILLS

Please give a minimum of 2 business days notice for completion of any medical forms/school forms/letters and requests for medication refills.

APPOINTMENT "NO SHOWS" AND CANCELLATIONS

There is a \$25.00 fee per patient for any "No Show" or cancellation of visits with less than 24 hours of notice.

COPIES OF MEDICAL RECORDS

There is a \$40.00 fee for release of personal copies of medical records. If medical records are being requested directly from another physician's office, there is no fee.

PAYMENTS ON ACCOUNTS

I have read a copy of Jenny Welham, MD LLC's Office Payment Policy with the effective date of July 1, 2016. We accept cash, check and credit card payments. Please make checks payable to *Jenny Welham, MD LLC*. Payment is due in full prior to services rendered if you have no insurance and/or if your visit is not a covered benefit of your insurance plan.

I hereby authorize the release of medical information to my insurance carriers concerning my illness and treatment and hereby assign all payments for medical services to my doctor. I understand I am responsible for payment of any amount not covered by my insurance.

I understand all of the information that has been provided to me as stated above.

Name of Patient _____ Date _____

Signature _____

(Parent or Legal Guardian Signature)

Print Your Name _____

Relationship to Patient _____



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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient _____

Date of Birth _____

Reports to be Disclosed

- | | |
|---|---|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Growth Chart |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Billing Claim Forms |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> Other |
| <input type="checkbox"/> All Medical Records | |

Records Release From

Name of Doctor _____

Phone _____

Address _____

Fax _____

Records Released To

Jenny H. Welham, MD FAAP
1401 S. Beretania St. Ste. 370
Honolulu, Hawaii 96814

Authorization

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described above. I understand:

1. This authorization expires 180 days from the date of my signature unless I specify otherwise.
Expiration _____
2. I may revoke this authorization at any time by notifying Jenny Welham MD LLC in writing. If I revoke the authorization, I understand that it will have no effect on actions Jenny Welham MD LLC took in good faith before receiving the revocation.
3. The information released may contain information related to AIDS or HIV infection drug or alcohol abuse behavioral health or psychiatric care, except for psychotherapy notes.
4. Jenny Welham MD LLC may not withhold treatment or payment based on my completion of this form.
5. Jenny Welham MD LLC reserves the right to verify my identity or guardianship.

Signature _____

Date _____

Printed Name _____

Relationship to Patient _____