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 Female
Mother Name (Last, First, M.I.)**:**		**DOB:**	**Occupation:**
Address:	**City/State:**	**Zipcode:**	**Mom Mobile #:**
Employer:			**Work #:**
Email:			**Home #:**
Father Name (Last, First, M.I.)**:**		**DOB:**	**Occupation:**
Address: same as above	**City/State:**	**Zipcode:**	**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:

Please Provide Your Insurance Card And Identification To Our Front Office Staff To Make A Copy For Our Records

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**? No Yes

PATIENT MEDICAL HISTORY

ALLERGIES: NO YES; please describe:

DOES YOUR CHILD TAKE Fluoride Vitamins Supplements Special diet Other Treatments? If yes, please explain:

HAS YOUR CHILD HAD ANY SURGERIES? No YES; please list year and type of surgery below:

HAS YOUR CHILD HAD ANY HOSPITALIZATONS/ILLNESSES/INJURIES? No YES If yes, please list year and explain below:

HAS YOUR CHILD SEEN ANY SPECIALISTS? No 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
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
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

___ History and Physical Exam
___ Consultation Report
___ Progress Notes
___ Radiology Reports
___ Laboratory/Pathology Reports
___ **Immunization Record**
___ **Growth Chart**
___ Billing Claim Forms
___ Operative Reports
___ Other
___ All Medical Records

Records Release From

Name of Doctor _____ Phone _____

Address _____ Fax _____

_____

_____

Records Released To

Jenny Welham MD LLC

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 _____