Hawai'i Infectious Disease Associates
Heath Chung, MD./Eric Kajioka MD./Benjamin Thomas, MD./James Joyner, MD
John Raymond Go, MD./ Lorrance Majewski, DO.

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New Patient Form

Patient Information

Last Name_____, First Name_____,MI_____

Date of Birth_____SSN# _____ [ ] Male [ ] Female

Address:_____

City, State, Zip: _____

Home Phone: (_____) _____ / Cell Phone: (_____) _____

Emergency Contact: (_____)_____Relationship:_____

Marital Status: [ ] Single [ ] Married [ ] Other_____

Race:_____ Language:_____

Occupation:_____Employer:_____

Work Address:_____

Work Phone: (___)_____-_____ ext._____Email:_____

Insurance Information

Primary Insurance: _____MEM No:_____

Subscriber: _____Relationship_____

Secondary Insurance: _____MEM No: _____

Subscriber: _____Relationship:_____

***Please bring in your HI-DL/ID, Insurance Card(s), and Medication List**

Social History
Do you smoke? [ ] Yes [ ] No [ ] Former Smoker (how long ago?)_____
Type: [ ] Cigarettes [ ] Tobacco Pipe [ ]Cigars [ ] Vape [ ]Other_____

Allergies		
Do you have any allergies to medication?	Yes	No
What type of medication(s) are you allergic to		

Medication Type	**Medication Reaction**	**Mild**	**Severe**
1.			
2.			
3.			
4.			
5.			

Patient Family History (please check all that apply)
[ ] Hypertension [ ] Hyperthyroidism [ ] Hypothyroidism [ ] Lyme Disease
[ ] Macular Degeneration [ ] Multiple Sclerosis [ ] Narcolepsy [ ] Insomnia
[ ] Ischemic Bowel Disease [ ] Kidney Stones [ ] Lupus
Other_____

Current List of Medication

(List current Medications that you are taking, including off the counter Medications)

Medication	Dose	Frequency
Example: Tylenol	325mg	1-2 tablets every 4-6 hours
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Authorization

I authorize release of confidential medical information to the following contact person(s)

Name:_____	Name:_____
Phone ( )_____	Phone ( )_____
Relationship_____	Relationship_____

I verify that the above information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to Hawaii Infectious Disease Associates. Heath Chung,MD / Dr. James Joyner, MD/ Eric Kajioka, MD/ Benjamin Thomas, MD/ John Raymond Go, MD, & Lorrance Majewski, DO services furnished to me.

_____ _____

Signature of Patient/Legal Guardian Date

I authorize Hawaii Infectious Disease Associates. Heath Chung,MD / Dr. James Joyner, MD/ Eric Kajioka, MD/ Benjamin Thomas, MD/ John Raymond Go, MD, & Lorrance Majewski, DO to disclose/request my health information including copies of records as necessary to/from

1. Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment charges.
2. Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.
3. Any insurance company that provides liability insurance coverage for Hawaii Infectious Disease Associates. Heath Chung,MD / Dr. James Joyner, MD/ Eric Kajioka, MD/ Benjamin Thomas, MD/ John Raymond Go, MD, & Lorrance Majewski, DO to evaluate clinical performance.

4. Any Workers compensation, No Fault, or administrative proceeding for the purpose of evaluating my medical condition.

All medical information with no exceptions, will be disclosed/requested as necessary to/from above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end two (2) years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient/Legal Guardian Date