PARTICIPANT DEMOGRAPHICS SHEET

Name: ____

DOB: ______/_____/________________ Age: _____________ Gender: ☐ M ☐ F

Address: ____

City: ____________________________ Zip code: ______________________

Home phone: ______________________ Cell phone: ____________________

Email: ____

Preferred contact method: ☐ Home ☐ Cell ☐ Email ☐ Text

Primary Care Physician: ______________________________________

Specialists: ____

Allergies: ____

Insurance Information

Primary insurance holder: ______________________________________

Subscriber's name: ____

Subscriber's date of birth: ______________________________________

Secondary insurance holder: ______________________________________

Subscriber's name: ____

Subscriber's date of birth: ______________________________________

Subscriber's relationship to participant: ___________________________

Emergecy Information

Name: ____

Relationship to participant: ____________________ Phone number: ______________

Ekahi Health Center
500 Ala Moana Blvd Suite 6-D
Honolulu, HI 96813
P: (808) 777-4000 F: (808) 447-0571

'EKAHI Health

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Physician/s Name/s: ____

TO: ____

____

RE: Patient Name: ____

Birth date: ______ / ______ / ________

I authorize and request the disclosure of my protected health information for the purpose of treatment and coordination of care. I expressly request that the custodian of record of the provider above, disclose to 'Ekahi Health, my protected health information related to the following:

- Most recent EKG
- Most recent past medical history, medication list, and physical examination
- Most recent blood chemistries including lipid panel, HgA1c or fasting glucose if person is diabetic, and electrolyte and renal function if person has kidney disease.

I understand that, unless withdrawn, this authorization will expire 1 (one) year from the date of signature. A photocopy of this form will be considered valid and original.

Full name: ______________________________ Date: ______ / ______ / ________

Signature: ______________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been notified of 'Ekahi Health's "Notice of Privacy Practices" (the "Notice"). It is posted in your office, and I was informed that I may also obtain a printed copy of the Notice from your office if desired.

By signing below, I acknowledge that I have been offered and reviewed a copy of the Notice for 'Ekahi Health.

______________________________ ____/____/_____
Patient Signature Date

____
Print name of patient

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ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT & INSURANCE FINANCIAL POLICY

By signing, I acknowledge that I have read, received, understand and agree to 'Ekahi Health's Payment and Insurance Financial Policy.

_______________________________________ ____/____/_____
Patient Signature Date

____
Print name of patient

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