National Kidney Foundation® of Hawaii

National Kidney Foundation of Hawaii (NKFH)
Health Clinic

Patient Information

Name: _____,_____ Sex: ☐ M ☐ F Birth Date: _____
Last First MI

Race/Ethnicity (select all that apply):
☐ American Indian or Alaska Native
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian: _____
☐ Black or African American
☐ Micronesian
☐ Native Hawaiian
☐ Samoan
☐ Tongan
☐ Other Pacific Islander: _____
☐ White/Caucasian
☐ Hispanic/Latino

SSN:_____Address: _____ City_____ State _____ Zip code_____

Phone: (Mobile)_____ (Home) _____ (Work) _____

Email: _____

Marital Status (select one): ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Other:_____

Emergency Contact

Name:_____Phone No: _____Relationship: _____

Insurance Information

Primary Insurance:_____Subscriber/Member No: _____

Subscriber Name: _____, _____ Sex: ☐ M ☐ F
Last First MI

Birth Date:_____SSN:_____Relationship to Subscriber:_____

Secondary Insurance: _____ Subscriber/Member No:_____

Subscriber Name:_____,_____ Sex: ☐ M ☐ F
Last First MI

Birth Date:_____SSN:_____Relationship to Subscriber:_____

Additional Information

Patient Employer: _____ Spouse Employer: _____

Patient Occupation: _____ Spouse Occupation: _____

Spouse Name: _____

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AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND A RELEASE OF INFORMATION TO INSURANCE COMPANY AND ACKNOWLEDGMENT OF RESPONSIBILITY FOR PAYMENT FOR PROVIDER SERVICES

I have reviewed my demographic and insurance data and certify that it is true and complete. I hereby acknowledge that I have received from NKFH a copy of the Notice of Privacy Practices. I hereby give my consent to any health care provider at NKFH to provide whatever treatment is deemed necessary. I authorize NKFH to release information to AND/OR, receive information from all healthcare providers who are involved with my medical care for following purposes including, but not limited to diagnostic/evaluation/referral, treatment planning/ongoing treatment, and coordination of services and other specific information needed for my medical care. I authorize the release of the following information for social reports, medical reports, history of all medications used in treatment, treatment goals/progress notes and any other specific treatment deemed necessary. I hereby authorize NKFH to its representative to release to my insurance company or its representative any information including the diagnosis and the records, or any treatment or examination rendered to me during the periods of such medical and surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Champus, Private Insurance, any other health plan to NKFH. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. I understand that I will be assessed a $15.00 charge for balance over 90 days. In event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize said assignee to release all information necessary to secure payment.

Print Name: _____

Signature: _____ Date: _____

Please list specific relatives or support persons whom you authorize and give NKFH permission to share your health records with below. If you do not want any relatives or support person authorized, please input below N/A (Not Applicable)

Names:	Contact Information:
1._____	_____
2._____	_____
3._____	_____

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HEALTH HISTORY please check off if you previously had, or presently have, any of the following diseases:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety/Panic attack
- ☐ Bleeding Disorder
- ☐ Cancer/Tumor
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Lung Trouble
- ☐ Prostate Trouble
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted
- ☐ Skin Disorder
- ☐ Stroke
- ☐ Thyroid Trouble
- ☐ Tuberculosis/Positive
- ☐ Other Specify: _____

CURRENT MEDICATIONS list your present medications and dose, *including* supplements and birth control pills: ***NOTE: If you have a separate list, just write "See List"***

- ☐ No medications
- ☐ No Over-The-Counter medications/supplements
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Surgical Procedure/ Hospitalizations:

☐ No surgeries or procedures

YEAR	SURGERY / OPERATION	HOSPITAL / CITY & STATE

Allergies:

☐ No known drug allergy

DRUG / INGREDIENT	REACTION

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Family History:

For your family members below, follow the line across the page and fill in their age, health (good/poor) or death. Mark an "X" to indicate any illnesses that they have or ever had.

	Age	Alive	Deceased	Cause of Death	HEALTH ISSUES:	Alcohol / Drug	Allergies	Arthritis	Asthma	Blood Disease	Cancer	Colon Cancer	Coronary / Heart Disease	Diabetes	Genetic	Genitourinary (GU)	Gestational Diabetes	Gastrointestinal (GI)	Heart	Hypertension	Lipids	Neurological Disease	Prostate Cancer	Psychiatry	Pulmonary / Lung	Stroke	Thyroid
Mother																											
Father																											
Sister(s)																											
Brothers(s)																											
Children																											

Substance Use:

SMOKING STATUS (choose one):

☐ Never Smoker

☐ Former Smoker: Quit Date:_____ former packs per day:_____ x _____years

☐ Current Smoker: packs per day:_____ x _____years

Type: □ Cigarette □ Pipe Cigar □ E-Cig □ Other:_____

SMOKELESS TOBACCO STATUS (choose one):

☐ Never

☐ Former: Quit Date:_____ x _____years

☐ Current: _____years

Type: ☐ Snuff ☐ Chew

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ALCOHOL CONSUMPTION (choose one):

☐ No ☐ Yes: drinks per: day _____ week _____ month _____

RECREATIONAL DRUGS (choose one):

☐ No ☐ Yes, please specify _____

Religion:

☐ Rather not disclose

Is there any religious preference(s) in your medical care?

☐ No ☐ Yes, please specify _____

Education:

☐ High School ☐ College ☐ Graduate ☐ Trade

Do you have any medical background?

☐ No ☐ Yes, please specify _____

Regular Exercise (type of exercise, select all that apply):

☐ Walking ☐ Treadmill ☐ Running ☐ Other:
☐ Swimming ☐ Weightlifting ☐ Biking _____

On average, how many minutes per week do you exercise?_____ min/week

Special Diet:

☐ None ☐ Yes, please specify: _____

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TELEMEDICINE PATIENT CONSENT

I understand that my health care provider wishes me to engage in a telemedicine consultation. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider. I understand there are potential risks to this technology, including interruptions and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation my email will be used to web enable me for this consultation by NKFH. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care.

Print name: _____

Sign name: _____

Date: _____

CODE OF CONDUCT AGREEMENT

This Code of Conduct is an expression of our commitment to create supportive relationships and establish a culture of compassion and respect. As a participant, I agree to maintain a respectful environment by agreeing to the following; arriving on time or immediately notifying staff when unable to do so, being considerate of the rights of other participants and the NKFH Staff, refraining from the use of foul language, sarcasm, and disruptive behavior, refraining from the use of threatening, violent or menacing behavior, helping to maintain a supportive environment when engaging in a group setting, following the care plan established by me and NKFH staff, taking full responsibility for my health outcomes, respectfully approaching the staff if I have any concerns. NKFH is committed to providing compassionate, non-judgmental, respectful, and clinically appropriate care for you. Therefore, if I breach the Code of Conduct, I understand that an NKFH staff member will discuss this and any consequences with me.

Print name: _____

Sign name: _____

Date: _____

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Attention Patients:

We will be using an Automated System for Appointment Reminders

Prefer not to receive reminders (Please Circle): No

Prefer to receive reminders: (Please fill in all that apply)

Text Message: Indicate mobile phone number_____

Automated Phone Messages: Indicate phone number _____

Print name: _____

Sign name: _____

Date: _____

1314 S King St #1555, Honolulu, HI 96814 | P (808) 589-5900 | F (844) 763-3215 | www.kidneyhi.org