MEDICAL CLINIC, INC.

Philip H.K. Kuo, M.D. *Sylvia Wang, M.D.* *Myrna Kuo, M.D.* *Philip I.L. Kuo, M.D., Ph.D.*

Queen's Physician's Office Building II
1329 Lusitana Street, Suite 202
Honolulu, HI 96813
P(808) 523-1600 F(808) 526-0221

414 Uluniu Street
Kailua, Hawaii 96734
P(808) 261-8345
F(808) 262-5239

Patient Name:	**Date of Birth:**	**SSN:**	**Sex:** M / F
Home address:	**City:**	**State:**	**Zip Code:**
Billing address (If different than above):	**City:**	**State:**	**Zip Code:**
Telephone: Home:	Work:	Mobile:	
If patient is a child, parent(s) or guardian's name:			
Name of patient's employer:	Occupation/Title:		
Business phone:	Business Address:		
Person responsible for payment:	Address:		
PRIMARY INSURANCE INFORMATION			
Subscriber Name:	**Date of Birth:**	Subscriber SSN:	
Insurance Company Name:			
Member ID:	Effective Date:	Relationship to Insured:	
SECONDARY INSURANCE INFORMATION			
Subscriber Name:	**Date of Birth:**	Subscriber SSN:	
Insurance Company Name:			
Member ID:	Effective Date:	Relationship to Insured:	

Race (Choose ONE; most dominant)				**Ethnicity (Choose ONE):**	
☐	American Indian or Alaska Native	☐	Asian	☐	Hispanic or Latin
☐	Black/African American	☐	Native Hawaii/Other Pacific Islander	☐	Not Hispanic or Latin
☐	White/Caucasian	☐	Other (Please describe):	☐	REFUSED TO REPORT
☐	Hispanic	☐	UNREPORTED/REFUSED TO REPORT		
Language (Primary Language; most frequently used):				Translator Needed? ☐ Yes ☐ No	
Preferred Pharmacy (Please specify):					
May we take your picture for your electronic medical records? ☐ Yes ☐ No					

Emergency contact not residing with you:	**Relationship:**	**Phone:**
If patient is a child, who may authorize treatment for the child:	Relationship:	Phone:
Primary Care Physician:	Phone:	Fax:
Referring Physician:	Phone:	Fax:

*I have read the "**Notice of the Uses and Disclosures of Protected Health Information**" that was presented in your office. I was informed that I may also obtain a printed copy of the "**Notice**" from your receptionist. I hearby acknowledge that I received from Medical Clinic Inc. a copy of the "**Notice**".

Patient, Parent, or Guardian Signature: _____ **Date:** _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____

Pursuant to Chapter 323-C, Hawaii Revised Statutes, I hereby authorize Drs. Kuo/Wang to disclose my health information, including copies of medical records to: (a) any health insurance plan or company that provides insurance for me or the named patient, for the purposes of payment of charges; (b) any insurance company that provides liability insurance to Drs. Kuo/Wang, to evaluate clinical performance; (c) any worker's compensation, no-fault or administrative proceeding for the purpose of evaluating my medical condition. (d) Schools or places of work for the purpose of school or employment physical examination. (e) Any consulting physicians for the evaluation of my medical condition.

- This authorization shall cover the period of time from my first visit to my last visit.
- I understand that I can revoke this authorization at any time.
- This authorization shall end two years after the date of my last visit.

Name and relationship of person signing, if not the patient:

_____

Signed: _____ Date: _____
(Name of patient or parent or legal guardian of a minor)

INITIAL VISIT: Name: _____ Date: _____

Reason for visit:

Physicians:

Name	Specialty

Medications: □ None

Past Medical Hist: □ None

Drug Allergy: □ **NKDA**

Surgeries (Including dates): □ None

Hospitalizations (Including dates): □ None

Family History: Include any heart attack, cancer, or stroke and at what age.

Father	
Paternal Grandfather	
Paternal Grandmother	
Mother	
Maternal Grandfather	
Maternal Grandmother	
Siblings/Children	

Smoking History: □ Non-Smoker □ Current Smoker □ Previous Smoker