NEW PATIENT PLACEMENT REQUEST AND AUTHORIZATION

Date: ________________

Patient. Name: ____ DOB_____________ Gender: M____F____Other_____

Mailing Address: ____City: _________________ Zip: ___________

Phone: (home)________________________ (cell)_______________________ Email __________________________________

Primary Insurance: _______________________ Subscriber Name__________________________ DOB_______________
ID#____________________________________ Group#_________________________________ Date Started___________

Secondary Insurance______________________ Subscriber Name__________________________ DOB_______________
ID#____________________________________ Group#_________________________________ Date Started ___________

Who is your current Doctor or most recent Doctor? ____

Which Doctor(s) are your top 3 choices? (1)______________________(2)_______________________(3)__________________

Do you prefer a male or female Doctor? ___________________________

Do you have any urgent complaints or symptoms you need addressed right away? ☐ No ☐ Yes Please specify

____

How soon were you told by your previous Doctor when to see your new Doctor?____

Do you have: **Diabetes** ☐ No ☐ Yes **Hypertension** ☐ No ☐ Yes **Heart Disease** ☐ No ☐ Yes **COPD** ☐ No ☐ Yes
Kidney disease ☐ No ☐ Yes **Dialysis** ☐ No ☐ Yes **Other** __________________________

Please list all medications you are currently taking (include supplements and over the counter):______________________________

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Do you take any long-term medications for pain or anxiety?" ☐ No ☐ Yes Please specify:_________________________________

____

How long will your current medications last? ____

Do you have any Motor Vehicle Accident injuries? ☐ No ☐ Yes If Yes, are your injuries still being treated? ☐ No ☐ Yes

Do you have any Industrial Work Accidents? ☐ No ☐ Yes If Yes, are your injuries still being treated? ☐ No ☐ Yes

Minor Children only: Is your child physically or mentally challenged?: ☐ No ☐ Yes
Are your child's vaccinations up-to-date?: ☐ No ☐ Yes

Who referred you to EAST HAWAII I.P.A?____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize EAST HAWAII I.P.A. and its members, officers, directors, employees, contractors, agents, representatives, and any of its affiliated organizations (collectively, "EHIIPA") to use and disclose any and all information (including protected health information) I provide to EHIIPA ("My Information") for the purpose of finding a new Doctor or health services for me.

I understand that my authorizing the use and disclosure of My Information is voluntary. I understand that unless expressly limited by me in writing below, I am specifically authorizing EHIIPA to release any and all of My Information including any sensitive medical information that may appear in my medical record including records for mental health treatment; pain management; sexually transmitted diseases; AIDS/HIV treatment; genetic tests; and program records for alcohol/drug treatment programs.

Check one or more of the following types of health information you DO NOT want released. If you do not check any of the following items, the health information released may include any of the following:

☐ Alcohol and/or drug dependency treatment records ☐ Genetic Tests

☐ Human immunodeficiency virus (HIV results, diagnosis, and/or treatment. ☐ Mental Health Records

☐ Other: ____

I can cancel this authorization at any time by writing to the Executive Director of EAST HAWAII I.P.A. I understand that once My Information has been released according to the terms of this authorization, My Information cannot be recalled. Any disclosure of My Information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. This authorization will expire in one (1) year from the date signed below unless otherwise revoked or unless another date or event is entered here________________________________. If a date or event is not specified, this authorization will expire one (1) year from my date of signature below.

I hereby release EHIIPA from all liability and all claims of any nature whatsoever pertaining to the use and disclosure of My Information, or of any professional opinions, findings, or recommendations as contained in the records released to or by EHIIPA. I understand that EHIIPA is not obligated to find a new Doctor or health services for me and there is no guarantee that EHIIPA will be able to do so.

SIGNATURE

Signature of Patient or Legally Responsible Party __________________________________ Date _______________

Relationship to patient, if not signed by patient __________________________________

Witness ____ Date _______________

For office use only

Accept Pt: **Y** **N** MD Accepting patient: _______________ Initial Appt made? **Y** **N**

Release of Information complete? **Y** **N** Appt date:_____________

eCW record created? **Y** **N**

EAST HAWAII I.P.A. Staff Initial________