CONFIDENTIAL
Ali'i Nani Aesthetic Medicine
Registration Information

Where did you hear about us?
□ Google Search □Google Ads □Instagram □Livin Hawaii TV
□ Facebook □ Referred by:______________________
□ Other______________________

Date:___/___/___ Email Address:___________________ Home Phone: (___) _____-____________ Cell Phone: (___) _____-_____________

Patient's name: ____, ____ _______________
LAST FIRST MI

Street Address:____

City:_____________________________State:_____________________ Zip:_______________________ Race:___________________

Gender □ Male □ Female Date of Birth: ______/______/______

Ethnicity:____________________________ Occupation:__________________________

Name of Spouse:____

In case of emergency, who should be notified?_________________________Relationship:_________________ Phone:(___)-______-_______

SOCIAL HISTORY
Home situation
□ Single □ Married □ Divorced □ Widowed □ Domestic Partnership □ Children________ Are they healthy?______________

Employment
□ Full-time □ Part-time □ Retired □ Disabled □ Homemaker

Occupation (type of work/job):____

Habits: Do you smoke? □ No □ Yes If Yes, how many packs a day?______Year started: ______ Year quit:______________

Do you drink alcohol? □ No □ Yes Year quit:_______

In the past year, have you ever had 8 or more drinks on one occasion or had 14 drinks (7 for woman) in one week? □ No □ Yes

Have you ever had problems with drug use?______________________________

PAST MEDICAL HISTORY
Please list other diseases from which you currently suffer (heart, lung, etc.):____

____

____

Please list other medical conditions from which you have suffered in the past:____

____

____

Please list any surgeries/procedures/operations you have had, reason for surgery, and date of surgery:____________________________

____

____

MEDICATIONS

Prescription medications	***Dose***	***How often taken***

Over-the-counter medications	***Dose***	***How often taken***

Herbal preparations	***Dose***	***How often taken***

ALLERGIES OR ADVERSE DRUG REACTIONS (Please list drug and type of reaction):
____

____

FAMILY HISTORY
Place an 'X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited disorder)								

Mother □ Alive □ Deceased Age:______ Medical conditions:____

Father □ Alive □ Deceased Age:______ Medical conditions:____

SYSTEMS REVIEW Are you currently having any of the following symptoms? Check if yes.

Gastrointestinal
□ Poor appetite
□ Abdominal pain
□ Indigestion
□ Trouble swallowing
□ Diarrhea
□ Constipation
□ Change in bowel habits
□ Nausea or vomiting
□ Rectal bleeding or blood in stools
□ History of liver disease or abnormal liver tests

General
□ Weight gain/loss of 10+ lbs during last 6 months
□ Poor sleep
□ Fever
□ Headache
□ Depression

Cardiovascular
□ Chest pain
□ History of angina or heart attack
□ History of high blood pressure
□ History of irregular heart beat
□ History of poor circulation

Eyes, Ears, Nose, Throat
□ Blurred vision
□ Other change in vision
□ History of glaucoma or cataract
□ Loss of hearing
□ Ringing in ears
□ Sinus problems
□ Hoarseness

Pulmonary/Lungs
□ Shortness of breath
□ Persistent cough
□ Coughing up blood
□ Asthma or wheezing

Genitourinary
□ Frequent or painful urination
□ Blood in urine
□ Urinary incontinence

Muscle/Joint/Bone
□ Swelling of ankles or legs
Pain, weakness or numbness in
□ Arms or hands
□ Back or hips
□ Legs or feet
□ Neck or shoulders

Skin
□ Itching
□ Easy bruising
□ Change in moles

Neurologic
□ History of stroke
□ Blackouts or loss of consciousness

Endocrine
□ History of diabetes
□ History of thyroid disease
□ Change in tolerance to hot or cold weather
□ Excessive thirst

Women only
□ Abnormal Pap Smear
□ Bleeding between periods
Date of last Mammogram:____

Men only
PSA Level_______________ When?__________________ Results?__________________________

Anything else?
□ Are you experiencing an unusually stressful situation?
□ Are there any specific personal issues you would like to bring up at the time of your visit?

Ali'i Nani Aesthetic Medicine
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Ali'i Nani Aesthetic Medicine to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and health care Operations (TPO). The Notice of Privacy Practices provided by Ali'i Nani Aesthetic Medicine describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Ali'i Nani Aesthetic Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices maybe obtained by forwarding a written request to:

Ali'i Nani Aesthetic Medicine
579 Farrington Highway, Suite 206
Kapolei, HI 96707

With this consent, Ali'i Nani Aesthetic Medicine may call my home or other alternate location and leave a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, or any calls pertaining to my clinical care.

With this consent, Ali'i Nani Aesthetic Medicine may mail my home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Ali'i Nani Aesthetic Medicine may use email and other electronic means that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Ali'i Nani Aesthetic Medicine restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Ali'i Nani Aesthetic Medicine to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Ali'i Nani Aesthetic Medicine may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____ ______________________
Print Patient's Name Date

____
Print Name of Legal Guardian, if applicable

Ali'i Nani Aesthetic Medicine

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (hereafter referred to as "PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1 USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office involved in your care and treatment for the purpose of providing health care services to you.

We will share your PHI with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object. These situations include: When Required By Law, for reasons related to Public Health, when someone may be exposed to a Communicable Diseases, for Health Oversight purposes (such as audits, investigations, and inspections), in cases of Abuse or Neglect, to the Food and Drug Administration, for Legal Proceedings, to Law Enforcement, to Coroners, Funeral Directors, and Organ Donation purposes, for Research, Criminal Activity, Military Activity and National Security, to Workers' Compensation programs, and to a correctional facility if you are an inmate.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE PROVIDING You THE OPPORTUNITY TO AGREE OR OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you for so long as we maintain the PHI. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by sending written, specific instructions to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer, Graeme Reed MD at (808) 674-4300 for further information about the complaint process.

This notice was published and becomes effective on July 26, 2019.