New Patient Form

Foot & Ankle Institute of Hawaii | *Bunion Center of Hawaii* | *Wound & Vein Center of Hawaii*

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Aiea, Hawaii 96701

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Honolulu, Hawaii 96816

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Honolulu, Hawaii 96814

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www.FAIhawaii.com

Date_____/_____/_____ *Please Print Clearly*

Patient Name: _____
(First) *(MI)* *(Last)*

Social Security # _____ - _____ - _____ Date of Birth _____

Age _____ Sex _____ Primary Care Physician _____

Marital Status _____ Spouse's Name _____

Address _____
(Street) *(Apt #)*

_____
(City) *(State)* *(Zip)*

Home Phone # _____

Cell Phone # _____ May we leave a message? ☐ Yes ☐ No

Work Phone # _____ Email Address _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Contact# _____

How did you learn about our office?

☐ DOCTOR REFERRAL ☐ FRIEND/ FAMILY MEMBER ☐ INTERNET ☐ OTHER

DR. _____ WHO? _____

INSURANCE INFORMATION Please give the receptionist your insurance card(s) and photo ID for photocopy

Primary Insurance _____ Secondary Insurance _____

Subscriber's Name _____ Subscriber's Name _____

Birth Date _____ Birth Date _____

ID# _____ ID# _____

Group# _____ Group# _____

What brings you to our office? _____

_____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ NO ☐ YES (DESCRIBE) _____

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

MEDICAL HISTORY / REVIEW OF SYMPTOMS: (Circle all that apply)

Constitutional Symptoms:	Fever	Weight Loss	Nausea/Vomiting	Chills	Other: (describe)
Eyes:	Glasses	Contacts	Blurred Vision	Double Vision	
Head/Eyes/Ears/Nose/Throat:	Headaches	Eyes/Ear problems	Hoarseness	Sinus Infection	
Cardiovascular:	Chest Pain	High Blood Pressure	Heart Attack	Heart Disease	
	Arrhythmia	Heart Murmur	Poor Circulation	Swelling	
Respiratory:	Shortness of Breath	Asthma	Emphysema	Cough	
Gastro-Intestinal:	Decreased Appetite	Diarrhea	Constipation	Abdomen Pain	
Genito-Urinary:	Kidney Disease	Bladder Infection	Incontinence	Urgency	
Musculo-Skeletal:	Arthritis	Fractures	Gout	Joint Swelling	
Skin:	Rashes / Itching	Psoriasis	Bruise Easily	Masses/Lesions	
Neurologic:	Stroke	Seizures	Weakness	Numbness	
Psychologic:	Depression	Anxiety	Mental Disorder		
Endocrine:	Diabetes	Thyroid Problems			
Hematologic/Lymphatic:	HIV	Bleeding Disorder	Hepatitis	Cancer	
Use ambulatory aids?	Cane	Walker	Crutches	Wheelchair	
Females: Are you pregnant?	Yes	No	Post-menopausal	Breast-Feeding	Last menses:

Prior Surgeries & Year

_____
_____
_____
_____
_____
_____

Medications ☐ NONE

_____
_____
_____
_____
_____
_____

Allergies ☐ NONE

☐ ANTIBIOTIC
☐ ANESTHETIC ☐ IODINE
☐ ASPIRIN ☐ LATEX
☐ CODEINE ☐ SULFUR
☐ SHELLFISH ☐ TAPE
☐ OTHER _____

Social History ☐ NONE

☐ SMOKING ____PKS/DAY X _____YRS
☐ ALCOHOL _____ DAYS/WEEK
☐ DRUGS
☐ STD
☐ OTHER _____

Family Medical History

☐ GI PROBLEM ☐ DIABETES ☐ POOR CIRCULATION ☐ HEART DISEASE ☐ BLEEDING DISORDER ☐ CANCER
☐ KIDNEY DISEASE ☐ LUNG DISEASE ☐ GOUT ☐ LIVER DISEASE ☐ OTHER ☐ OTHER

ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize payment of medical benefits provided by my insurance company policy or policies to Dr. Attilio Avino, Dr. Henry Louie, Dr. Lowell Tong for medical or surgical care.

_____ ✗_____

(PRINT Name of Insured) **(Authorized Signature of Subscriber or Patient)** **(Date)**

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I have been informed that if I am uncertain about any question on the form I should ask the doctor or the office staff for assistance. I hereby give permission to Dr. Avino, Dr. Louie and/or Dr. Tong to administer treatment and to perform such procedures deemed necessary in the diagnosis and/or treatment of the extremity condition.

✗_____

(Patient Signature) **(Date)**

ATTILIO AVINO JR, DPM
HENRY LOUIE, MD
LOWELL TONG, DPM

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Parent or Authorized Representative (if applicable)

✗_____

Signature Date

Foot & Ankle Institute of Hawaii, LLC
Bunion Center of Hawaii, LLC
Wound & Vein Center of Hawaii, LLC
Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations / referrals needed to seek treatment in this office.
- You must inform the office of all insurance changes and authorizations/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Copayments for office services are due at the time of service.
- There is a $25.00 service charge for all returned checks.
- There is a $25.00 charge for cancellations and appointment changes made less than 24 hours in advance.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any services rendered.
- I understand that I am financially responsible for any balance due on my account. Past due accounts are subject to collection proceedings.

Printed Name of Patient/Responsible Party: _____

Signature of Patient/Responsible Party: ✗ _____

Date: _____