

Deryll U. Ambrocio, MD
 500 Ala Moana Boulevard, Suite 300
 Honolulu, HI 96813
 Five Waterfront Plaza
 808-531-7111
 808-528-5507 (fax)

(Must be filled out in pen.)

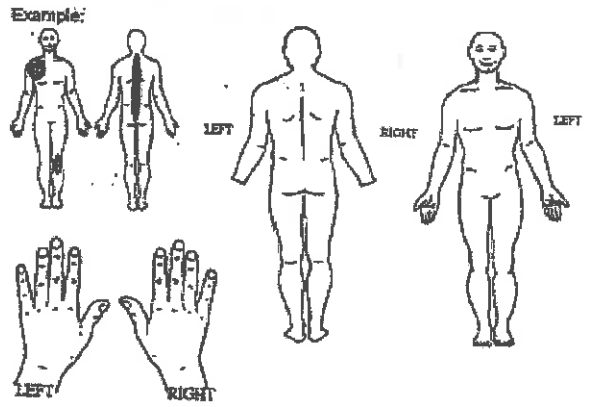
Birthplace _____

Name _____ Birthdate ____/____/____
 Last First MI Maiden Month Day Year
 Address _____ Age _____ Sex: F M SSN: _____
 Home phone _____ Cell phone _____
 Marital Status: Never Married Married Divorced Separated Widowed
 Work phone _____ Other _____
 Spouse/Significant Other: Alive/Age _____ Deceased/Age _____
 Education: Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____
 Occupation _____ Number of hours worked/ average per week _____

Name of person making referral: _____
 Name of Primary Care Physician: _____
 Do you have an orthopedic surgeon? Yes No If yes, Name: _____
 Describe your present symptoms briefly: _____

Date symptoms began (approximate): _____
 Diagnosis: _____
 Previous treatment for this problem (include physical therapy, surgery and injections, medications.): _____

Please shade all the locations of your pain over the past week on the body figures and hands.



Rheumatologic (arthritis) History

At any time have you or a blood relative had any of the following? (check if "yes")

Self	Relative (Relationship)	Self	Relative (Relationship)
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

Social History

Do you drink caffeinated beverages? Yes No
 Cups/ glasses per day? _____
 Do you smoke? Yes No Past-How long ago? _____
 Do you drink alcohol? Yes No Number per week? _____
 Has anyone ever told you to cut down on your drinking?
 Yes No
 Do you use drugs for reasons that are not Medical? Yes No
 If yes, please list _____
 Do you exercise regularly? Yes No

Type _____
 Amount per week? _____
 How many hours of sleep do you get per night? _____
 Do you get enough sleep at night? Yes No
 Do you wake up feeling rested? Yes No

Past Medical History

Do you now or have ever had: (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Anemia
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bad Headaches	<input type="checkbox"/> Colitis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High cholesterol		

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? Yes No Describe: _____

Any other serious injuries? Yes No Describe: _____

Family History

	If Living		If Deceased	
	Age	Health	Age of Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____
 Number of children _____ Number living _____ Number deceased _____ List age of each _____
 Health of children _____

Do you know of any blood relatives who has or had (check and give relationship):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Goiter _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Colitis _____ |
| <input type="checkbox"/> Psoriasis _____ | <input type="checkbox"/> Asthma _____ | | |

Medications

Drug allergies: No Yes To what? _____

Type of Reaction: _____

Present medications (List any medications you are taking, including all over-the-counter medications also.)

Name of Drug	Dose (Include strength & pills taken per day)	How long has medication been taken?	Please check: Helped?		
			A lot	Some	Not at All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Name _____ Date _____ Physician Initials _____

Employer Information

Employer Name _____
Address _____

Insurance Information

* Primary Insurance _____ Subscriber Name _____
Member Number _____ Subscriber Date of Birth _____
Subscriber SSN _____ Relationship _____

*Secondary Insurance _____ Subscriber Name _____
Member Number _____ Subscriber Date of Birth _____
Subscriber SSN _____ Relationship _____

Emergency Contacts

Name _____ Phone Number _____
Address _____
Relationship _____

Name _____ Phone Number _____
Address _____
Relationship _____

The following information is presented for informational purposes and as formal notification:

1. The practice of Deryll U. Ambrocio, M.D. do not participate with Workmen’s Compensation or No-Fault and that you attest that the issues at hand are not related to such events.
2. That, by tradition, a copy of medical records will be forwarded at no charge to a requesting doctor’s office. All other records requested are subject to copying charges.
3. As of January 1, 2010, charge will occur for certain forms and for preparation of letters to outside entities. The volume of such requests has dramatically increased. Examples are jury duty letters, travel-related letters, FMLA forms and insurance company appeal letters. The charge will be \$10.00 unless otherwise stated in advance.
4. Finally, we reserve the right to impose a \$25.00 fee for “no-show” or late cancellation of appointments. Please call to cancel/reschedule at least 24 hours prior to your scheduled appointment.

Patient’s Signature _____ Date _____

Deryll U. Ambrocio, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, the doctors and staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the doctors and staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, the doctors and staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the doctors and staff may speak and release my PHI to the following family members, friends or parties listed below:

<u>Name</u>	<u>Relationship</u>	<u>Name</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that if my PHI is disclosed to a party who is not required to comply with federal privacy protection policies, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This consent covers the period of time from my first visit until I revoke my consent in writing. I release the doctors and staff from all legal responsibility that may arise from this authorization.

By signing this form, I am consenting to the doctors and staff's use and disclosure of 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.

Signature of Patient or Legal Guardian

Date

Print Name of Patient

Print Name of Legal Guardian