PATIENT REGISTRATION INFORMATION

NAME: _____ _____ _____
LAST FIRST MI

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Other Phone: _____ **Email Address:** _____

Birthdate: _____ **Sex: M F** **Social Security No.**_____

Employer: _____ **Marital Status:** Married Divorced Single Widowed Separated Other

Primary Physician: _____

Who referred you?: _____

Persons to Contact in Emergency:

Primary Contact: _____ **Relationship:** _____ **Telephone:** _____

Secondary Contact: _____ **Relationship:** _____ **Telephone:** _____

RESPONSIBLE PARTY

Party Responsible for Payment: Self Spouse Parent Other

Name (if other than self): _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

PRIMARY INSURANCE

Primary Medical Insurance: _____

Insured Party: Self Spouse Parent Other Sex: M F Date of Birth: _____

ID No. / Social Security No.: _____ **Group Plan No.:** _____

Name (if other than self): _____

SECONDARY INSURANCE

Primary Medical Insurance: _____

Insured Party: Self Spouse Parent Other Sex: M F Date of Birth: _____

ID No. / Social Security No.: _____ **Group Plan No.:** _____

Name (if other than self): _____

I authorize the release of any medical information necessary to process claims pertinent to my care with the above physician and authorize my insurance company to make payment directly to my physician.

Date: _____ **Signature:** _____

Allergies: _____

1029 Kapahulu Ave., #306
Honolulu, Hawaii 96816
Telephone (808) 729-9087
Fax (808) 218-7859

PACIFIC UROLOGY, INC- DAVID CHOU, M.D., F.A.C.S.

OFFICE POLICY ON PRIVACY PRACTICES
PATIENT DISCLOSURE

In accordance with the American Medical Association Code of Ethics, I believe that the patient-physician relationship is based on trust and the confidentiality of communication. The free and uninhibited disclosures of personal information within this relationship are the cornerstone of good medical care.

The privacy of your medical records is of the utmost importance to my staff and me. I have therefore taken measures to ensure that your medical records receive the highest level of confidentiality and security. This office adheres to the following procedures to ensure protection of your private medical records.

- My office staff has received education and training regarding the use and handling of patients' protected health information
- Your records are secured in a locked facility during non-office hours
- Access to office keys are limited to the staff of this facility, building management and cleaning staff
- Access to electronic information is secured via passwords
- Your private medical information is only released as required or permitted by state and federal law

In order to continue to provide personalized service to our patients and function effectively:

- We utilize outside services, such as transcriptionists or consultants
- Your name, status and location may be revealed within the office setting
- Laboratory, test results, and clinical notes may be shared with other physician(s) participating in your medical care.
- Confidentiality can be expanded to exclude information issued to insurance companies by choosing to not use any health insurance or third party payment as payment for services. In this scenario any and all health care services rendered, we will submit your charges to your health insurance, other third party, or employ the services of a collection agency
- If you request copies of your records, there will be a charge of $1.00 per page

I have read, understand and agree to the privacy practices of David Chou, M.D. and have received a copy of my patient rights and responsibilities.

_____ _____
Patient Signature Date

_____ _____
Print Patient Name Date of Birth

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PACIFIC UROLOGY, INC- DAVID CHOU, M.D., F.A.C.S.

CONSENT TO RELEASE
PROTECTED HEALTH INFORMATION PURSUANT TO H.R.S. 323C

Authorization is hereby given to David Chou, M.D. to disclose and be furnished any and all health care information including medical records, reports, x-rays, diagnostic test results, bills, and payment records with respect to medical treatment or qualified healthcare operations provided to:

a) any health insurance plan or company that provides insurance coverage for me for the purpose of payment of charges;
b) any insurance company that provides liability insurance coverage for Dr. David Chou for the purpose of evaluating the treatment rendered to me;
c) mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results. If this medical record contains information about HIV testing and/or AIDS diagnosis or treatment, separate consent must be given to have this information released.

☐ I consent to have my HIV testing, AIDS diagnosis, drug and/or alcohol abuse and/or mental health records released

☐ I do not consent to have my HIV testing, AIDS diagnosis, drug and/or alcohol abuse and/or mental health records released

Or

d) to (specify individual/group/organization) _____for the purposes of _____.

This authorization also gives David Chou, M.D. permission to speak to the following spouse, family member, relative or friend regarding my medical information and treatment:

Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

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.
I release David Chou, M.D. from all legal responsibility that may arise from this authorization.

_____ _____
Patient Signature Date

_____ _____
Print Patient Name Date of Birth

_____
Signature of Parent or Legal Guardian if Minor

PACIFIC UROLOGY, INC / DR. DAVID S. CHOU MD, FACS Today's Date: _____

Patient Health Questionaire

Last name _____ First Name _____ DOB _____ M / F

	0=Not at all	1=Several Days	2=More than half the Days	3=Nearly Every Day
1)	Little interest or pleasure in doing things	0	1	2	3
2)	Feeling down, depressed or hopeless	0	1	2	3
3)	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4)	Feeling tired or having little energy	0	1	2	3
5)	Poor appetite or overeating	0	1	2	3
6)	Feeling bad about yourself-or that you're a failure or have let yourself or your family down	0	1	2	3
7)	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8)	Moving or speaking so slowly that other people could have noticed. Or, the opposite being so fidgety that you have been moving around a lot more than usual	0	1	2	3
9)	Thoughts that you would be better off dead or of hurting yourself in someway	0	1	2	3
10)	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult			

Tobacco Use: ☐ Current ☐ Previous ☐ Never Date Quit: _____

Year started _____

☐ Cigarettes Amt _____ packs per day

☐ Cigars Amt _____ # per week

☐ Smokeless / Chewing Amt _____ # per day

Alocohol Use: ☐ Yes ☐ No Date Quit: _____

Type: Beer / Wine / Other How often? _____ Per day / week

Colonoscopy Date: _____

Flu Vacc. Date: _____

Pneumonia Vacc. Date: _____

Mammogram Date: _____ Mastectomy: _____

Pap Smear Date: _____

Medication List: _____

Allergy / Reaction(s): _____

Personal Medical History: _____

Family Medical History: _____

Patient / Guardian Signature _____ Date: _____

PACIFIC UROLOGY, INC / DR. DAVID S. CHOU MD, FACS
Patient Health Questionnaire

Today's Date:_____
Last Name: _____ FIRST NAME: _____
DOB: _____

CHIEF COMPLAINTS / REASON FOR VISIT: _____

MARITAL STATUS: _____
LIVES W/: _____
 # CHILDREN: _____
EMPLOYMENT: _____

REVIEW OF SYMPTOMS (CHECK IF APPLICABLE):

GENERAL :	**GASTROINTESTINAL:**	**MENTAL STATUS:**
☐ FEVER	☐ NAUSEA	☐ DEPRESSION
☐ FATIGUE / WEAKNESS	☐ VOMITING	☐ MEMORY LOSS
☐ WEIGHT LOSS	☐ DIARRHEA	☐ INSOMNIA
☐ WEIGHT GAIN	☐ CONSTIPATION	☐ NERVOUSNESS
☐ CHILLS	☐ ABDOMINAL PAIN	**ENDOCRINOLOGY:**
☐ SWEATS	☐ ABDOMINAL BLOATING	☐ COLD INTOLERANCE
☐ ANOREXIA	☐ RECTAL PAIN	☐ HEAT INTOLERANCE
☐ SLEEP DISORDER	☐ RECTAL BLEEDING	☐ EXCESSIVE THIRST
☐ BEING TIRED ALL THE TIME	☐ BLACK TARRY STOOLS	☐ EXCESSIVE URINATION
EYES:	**MUSCULOSKELETAL:**	☐ ENLARGED GLANDS
☐ EYE DISEASE	☐ BACK PAIN	**HEME:**
☐ BLURRED VISION	☐ JOINT PAIN	☐ ABNORMAL BRUISING
☐ GLAUCOMA	☐ JOINT SWELLING	☐ BLEEDING
ENT:	☐ MUSCLE PAIN	☐ ANEMIA
☐ HEARING LOSS	**SKIN:**	☐ PHLEBITIS
☐ NOSEBLEEDS	☐ RASH	☐ PAST TRANSFUSIONS
☐ SORE THROAT	☐ ITCHING	☐ ENLARGED GLANDS
☐ BAD TASTE	**NEUROLOGIC:**	**ALLERGY:**
☐ SORE TONGUE	☐ HEADACHE	☐ RECURRENT INFECTIONS
☐ MOUTH SORES	☐ SEIZURES	☐ LATEX ALLERGY
CARDIOVASCULAR:	☐ WEAKNESS	
☐ CHEST PAIN	☐ NUMBNESS	
☐ SHORTNESS OF BREATH	☐ STROKE	
☐ WHEEZING	**PAST SURGICAL HISTORY (DATE / PROCEDURE) :**	
RESPIRATORY:		
☐ CHRONIC COUGH		
☐ SPITTING UP BLOOD		
☐ WHEEZING		

COMPLETED BY: _____