Dylan E. Lee, M.D. | Douglas W. Johnson, M.D.
1380 Lusitana Street, Suite 401
Honolulu, HI 96813
Phone: 808-531-7541 | Fax: 808-531-7542

Patient Information Sheet

Referred by: ____________________________

Patient Name: ____
Last First Middle Initial

Birthdate: ______________ **Gender:** M F **Social Security Number:** xxx-xx-_____ **Marital Status:** Single Married Divorced Widow

Home Phone: ____________________ **Cellular Phone:** _________________________
Email Address: ____
Occupation: ______________________ **Employed By**: ________________________**Phone**: _______________

Home Address: ____
Number Street
____
City State Zip code

Mailing Address: ____
Number Street
____
City State Zip code

Primary Insurance:
Insurance Name: ______________________
Subscriber ID: _________________________
Subscriber Name: ______________________
Subscriber Birthdate: ____________________

Secondary Insurance:
Insurance Name: _____________________
Subscriber ID: ________________________
Subscriber Name: _____________________
Subscriber Birthdate: __________________

Responsible Party Name: _____________________ DOB: ________________
Relationship to patient: _________________

Emergency Contact Name/Relationship: _________________________________
Phone: ______________________

I give my consent to be treated. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims. I understand that I can revoke this authorization at any time with written notice to Dylan E. Lee, MD Inc. I hereby authorize payment of medical benefits directly to Dylan E. Lee, MD Inc. I understand that I am financially responsible for all changes incurred and in the event that insurance payments are sent directly to me, I will remit payment to this office. In the event that my account becomes delinquent I will assume all responsibility for any attorney and collection agency costs. Your signature below signifies your understanding and willingness to comply with this policy.

______________ ____

Date Signature of Patient or Legal Guardian

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Medical History Form

Patient Name: ______________________________________ DOB: _______________ Todays Date: ______________

Primary Care Physician: _____________________________ Preferred Pharmacy: ______________________________

Reason for Visit:____

Past Medical History:
Do you have now, or ever had any of the following conditions:

[ ] Bronchitis	[ ] High Blood Pressure	[ ] Pacemaker	[ ] Diabetes
[ ] Emphysema	[ ] Chest Pain	[ ] Phlebitis	[ ] Thyroid
[ ] Asthma	[ ] Heart Attack	[ ] High Cholesterol	[ ] Kidney
[ ] Chronic Cough	[ ] Heart Murmur	[ ] Stroke	[ ] Prostate
[ ] Morning Cough	[ ] Irregular Heartbeat	[ ] Headaches/Migraines	[ ] Stomach
[ ] Bowel	[ ] Hepatitis/Yellow Skin	[ ] Glaucoma/Cataract	[ ] Arthritis/Joint Deformity
[ ] Convulsion/Epilepsy	[ ] Fainting	[ ] Hay Fever	[ ] Nasal Allergies
[ ] HIV/AIDS	[ ] Cancer Type: ______________________		[ ] **None of the above**

Other medical problems not listed above: ____
____

List any major surgeries: ____

Skin Disease History:
Have you ever had skin cancer? [ ] Yes [ ] No [ ] Not Sure
If yes, check what type: [ ] Basal Cell [ ] Squamous Cell [ ] Melanoma [ ] Not sure
Has anyone in your family ever had a skin cancer? [ ] Yes [ ] No If yes, Who: _____________________________
When exposed to the sun do you: [ ] Tan only [ ] Tan and Burn [ ] Burn

Medications:
Current Medications: ____
____
Are you allergic to any medications: [ ] Yes [ ] No If yes, please list: ____

Social history: Do you drink Alcohol? [ ] Yes [ ] No yes, _____ drinks per day
Do you smoke? [ ] Yes [ ] No If yes, ____ packs per day How long have you been smoking? _______ years
What are your hobbies? ____
What is your occupation? ____

Alerts:
Have you ever had dental anesthesia (Novacaine)? [ ] Yes [ ] No If yes, any bad reactions? [ ] Yes [ ] No
Are you allergic to Latex? [ ] Yes [ ] No
Are you pregnant? [ ] Yes [ ] No If yes, when is your due date? ________________
Do you use IV Drugs? [ ] Yes [ ] No
Do you bleed easily? [ ] Yes [ ] No If yes, are you on any blood thinners? [ ] Yes [ ] No
Do you have artificial joints? [ ] Yes [ ] No

Form completed by:
[ ] Patient [ ] Parent/Legal Guardian [ ] MA _____

OFFICE USE ONLY

____
Signature of Physician Date

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New Patient Consent to the Use and Disclosure of Health Information

For treatment, payment, and/or healthcare operations

I, _______________________________, understand that as a part of my care, the office of Dylan E. Lee, M.D. and Douglas W.
patient or parent/guardian if minor
Johnson, M.D. originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which 3rd party payers can verify that services billed were provided*
- *A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.*

I understand that a *Notice of Information Practices* that provides a more complete description of the information uses and disclosures is available for my review. I understand that I have the following rights and privileges:

- *The right to review the above notice prior to signing this consent*
- *The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations*

I understand that Dylan E. Lee, M.D., Inc. reserves the right to change the aforementioned notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Dylan E. Lee, M.D., Inc. change this notice, a copy of the revised notice will be sent to the address I've provided (or if I agree, email) upon my request.

I wish to have the following restrictions regarding the use of my health information:

____

____

____

I understand that as part of this office's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and I : *[ ] Accept* *[ ] Decline* *the terms of this consent*

____ _________________________

Patient signature (parent or legal guardian if minor) Date