ROYDEN E CHRISTENSEN D.O.
BYU-Hawaii Health Services
55-220 Kulanui St. #1728
Laie, Hi 96762
(808) 675-3510 Fax (808) 675-3506

PATIENT INFORMATION SHEET

Please print legibly

Name: _____ Birth date: _____
Last, First, M.I.
Parent/Guardian Name (if pt. under 18 years old): _____

Home Address: _____ Home Phone ( ) _____

Local/School Address: _____ Local Phone: ( ) _____

Social Security Number _____-_____-_____ Sex _____ Marital Status: _____

Employed By: _____ work phone _____ BYUH ID# _____
Account # _____

INSURANCE INFORMATION: Please fill in the appropriate Insurance Information.

DMBA STUDENT INSURANCE

DMBA ID# _____

Name: _____

Birth date: _____

Employer: _____
Email Address: _____

DMBA MANAGE CARE INSURANCE

Insurance Co _____

Policy Holder _____

Policy Holder Birth date: _____

Policy Holder SSN # _____
Address of Co. _____
Group # _____

EMERGENCY:

In case of emergency, please notify _____ phone _____
Relationship to you : _____

PERMISSION TO BE TREATED:
"I authorize the physicians and nurses employed by the BYU-HAWAII Student Health Center to provide me with reasonable and proper medical care as defined by today's standards."
"In accordance with Act 206 1995, I understand that I may have my symptom(s) or condition listed on my prescription label. I understand that I have the right to not have my condition or symptom(s) listed on the prescription label."

_____I wish to have my condition or symptom(s) listed on the prescription label.

_____I DO NOT wish to have my condition or symptom(s) listed on the prescription label.

Signature: _____ Date _____
Patient, Parent, Legal Guardian

Brigham Young University – Hawaii Health Services

MEDICAL HISTORY

Name ..... Age ..... Date of Birth .....
Please print

Student ID#
or SSI of Policy Holder .....Date .....

Medical History: To be filled out by the patient or guardian and reviewed by your health care provider. Information on the medical history and physical examination is confidential and released only to persons you authorize in writing.

Past Medical History

Major illnesses (list, date) .....
Surgeries (list, date) .....
Hospitalization (list, date) .....
Injuries (list, date) .....
ALLERGIES to medication/food (list med/food and type of reaction) .....
.....
Current medications and dosage .....

Habits

Diet ..... Number of meals/day
Exercise ..... hours/week ..... type of exercise
Any special dietary restriction? .....

General

Recent change in weight
Do you think you have an
Have you ever vomited for
Weight control?
Do you have any risk factors for AIDS?
Depression
Weakness
Have you ever put drugs In your vein?
Nervousness/anxiety
Fatigue

Females

.....Age menses began
.....# of pregnancies
.....# of deliveries
.....# of abortions (miscarriages or induced)
Menses every .... Days
Spotting between periods
Vaginal itching
.....How often do you examine your breasts?
.....Days of bleeding
vaginal discharge
History of sexually transmitted disease
Birth control method:.....

Males

.....How often do you examine your testicles for masses?
Testicular masses
Testicular pain
Discharge from penis
Sores on penis
History of sexually transmitted disease

Have you ever had or have a family history of:

Y N 1. Heart disease/surgery?
Y N 2. Diabetes or sugar in the urine?
Y N 3. A goiter or other thyroid disease?
Y N 4. High blood pressure?
Y N 5. Excessive bleeding?
Y N 6. A tumor, growth, cyst or cancer?
Y N 7. A dependency on medication or drugs?
Y N 8. A stroke?
Y N 9. Professional counseling for emotional problem?
Y N 10. Medical/hospitalization for an emotional problem?
Y N 11. Tuberculosis?
Y N 12. A knee injury?
Y N 13. Limb loss or deformities or other
Y N 14. Arthritis or swollen, painful joints
Y N 15. A back injury or deformity?
Y N 16. A pain or pressure in the chest?
Y N 17. Asthma or wheezing?
Y N 18. Stomach or intestinal ulcers?
Y N 19. Seizures, convulsions, or epilepsy?
Y N 20. Kidney disease or stones?
Y N 21. A suicide attempt
Y N 22. Anorexia or bulimia?

Do you have or have experienced during THIS YEAR:

Y N 23. Ear pain or any problem with hearing?
Y N 24. Eye discomfort or difficulty?
Y N 25. Frequent headaches?
Y N 26. Dizziness or fainting spells?
Y N 27. Hay fever or nasal problems?
Y N 28. Food allergies?
Y N 29. Hives or skin allergies?
Y N 30. Skin sores or rashes?
Y N 31. Warts or sores on feet?
Y N 32. A lump, new or changing mole?
Y N 33. Coughing, frequent sore throat?
Y N 34. Chest pain or shortness of breath?
Y N 35. Spitting or coughing up of blood?
Y N 36. Sweating at night?
Y N 37. Stomachaches, burning , or indigestion?
Y N 38. Urinary burning, frequent urination or or dark urine?
Y N 39. Difficulty starting urine or dribbling?
Y N 40. Pain in back, neck, or joints?
Y N 41. Difficulty walking, running, or lifting
Y N 42. A rupture or hernia?
Y N 43. Unexplained weight loss?
Y N 44. Frequent diarrhea, constipation, or unusual bowel movements?
Y N 45. Pain or bleeding when having bowel movements?
Y N 46. Any illness or injury not already noted?

Explain any 'yes' answers on a separate sheet (see receptionist).

BYU HEALTH CENTER OFFICE POLICY

OFFICE HOURS

The Health Center is open Monday through Friday between the hours of 8am – 12pm and 2pm to 5pm. Patient appointments are scheduled during these times.

APPOINTMENTS

Patients are seen by appointment only. Walk – in patients will be scheduled for an appointment upon availability. If you require immediate medical attention please call the Health Center as early in the day as possible so that arrangements can be made to accommodate your health care needs.

If you are unable to keep your scheduled appointment, please let us know as far in advance as possible. Your thoughtfulness will allow us to accommodate other patients who may wish to be seen.

BILLING OF SERVICES AND CLAIMS FILING

Insurance benefits for these plans will be made directly to the Health Center.
Any balance left after insurance payments and provider adjustments will be billed to you.
Payment is expected at the time of billing.

You are financially responsible for any services denied claims incurred here at the Health Center and are given until the end of the current semester to pay in full all debts owed.

DMBA STUDENT PLAN:

You are required to pay a $10 co payment at the time of service.

DMBA MANAGE CARE PLAN:

You are required to pay a $15 co payment at the time of service.

You are financially responsible for any services incurred here at the Health Center and are given until the end of the current semester to pay in full all debts owed.

MEDICATION REFILLS

The Health Center requires a 24 hours notice for refills.

If you are on routine medications, please check your medication supply before ordering a refill to make sure that you have enough medication to last 48 hours prior to ordering.

IN CASE OF EMERGENCIES

The Health Center is closed in the evening and on weekends and holidays. Should you require medical attention at such times, please call the BYU security office at 293-3911.

The security office will be able to put you in touch with the nurse-on-call.

NOTICE OF CONFIDENTIALITY PRACTICES

IMPORTANT: THIS NOTICE DEALS WITH THE SHARING OF INFORMATION FROM YOUR MEDICAL RECORDS. PLEASE READ IT CAREFULLY.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse or children. If you do not understand the terms for this notice, please ask for further explanation (Chapter 323c HRS)

NOTICE OF CONFIDENTIALITY PRACTICES

This notice deals with the sharing of information from your medical records. PLEASE READ CAREFULLY.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse or children. If you do not understand the terms for this notice, please ask for further explanation (Chapter 323c HRS).

- YOUR RIGHTS

  Under the new HIPPA law, you have the right to:

  - Inspect and request copies of your medical records or to appeal any denial of your request for inspection or copying.
  - Request that your health care provider append information to your medical record.
  - Receive a notice of your privacy rights by your health plan upon enrollment, annually and when their confidentiality practices are substantially amended.
  - Obtain a copy of this office's confidentiality practices.

- USES OF INFORMATION

  This office uses your protected health information to provide you with health care services. Under the law, your health information may also be used by such entities as health plans for the following purposes.

  - Payment to physicians and hospitals who provide you with health care.
  - Conducting quality assurance activities or outcomes assessment.
  - Reviewing the competence or qualification of health care professionals.
  - Performing accreditation, licensing or credentialing activities.
  - Analyzing health plan claims or health care records data.
  - Evaluating provider clinical performance.
  - Carrying out utilization management.
  - Conducting or arranging auditing services in accordance with statute, rule or accreditation requirements.

  Except for the purposes outlined above, your health information may not be disclosed without your authorization.

- LIMITING DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

  You have the right to limit disclosure of your protected health information if you choose to not use any health insurance or other third party payment as payment for services. In which case, you may only limit disclosure if you have advised the physician prior to the delivery of services and have paid for the health care services yourself.

I, the undersigned, state that I have read, understood and agree to all the terms listed above, **including the Notice of Confidentiality Practices**.

Signature: _____ Date: _____

PATIENT, PARENT OR LEGAL GUARDIAN

PERMISSION TO RELEASE MEDICAL INFORMATION TO PARENT(S)/SPOUSE/OTHER

Brigham Young University Hawaii Health Center

BYU – Hawai'i Health Services
55-220 Kulanui Street #1728
Laie, HI 96762
Ph.: (808) 293-3510 * Fax: (808) 293-3506

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

FOR OFFICE USE ONLY
Patient Name: _____
Account #: _____
Date of Visit: _____

By signing this form, you acknowledge that the BYU – Hawai'i Health Center has given you a copy or you have been offered a copy of the BYU – Hawai'i Student Health Center's Notice of Privacy Practices which explains how your health information will be handled in various situations. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency. If you have any questions, please feel free to talk with one of our personnel.

Check all that are true:
_____I have received the BYU – Hawai'i Health Center's Privacy Notice.
_____The BYU – Hawai'i Health Center has given me the chance to discuss any concerns and questions about the privacy of my health information.

I give permission to the BYUH-Hawaii Health Center to release information from my medical records to (print name of parent(s), spouse or other):

Name:_____Relationship:_____
Name:_____Relationship:_____

Signature of patient: _____Date: _____
PATIENT, PARENT OR LEGAL GUARDIAN (if signed by other than individual, state relationship)

BYU – Hawai'i Health Center staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? Yes No
2. Please explain why the patient was unable to sign an Acknowledgement Form and BYU – Hawai'i Health Center's efforts in trying to obtain the patient's signature:

_____
_____
_____

Signature: _____Date: _____
Health Center Staff Member