Daniel I Singer MD Inc.
Patient Registration Forms

LAST NAME	FIRST NAME	MIDDLE NAME
SEX ☐ M ☐ F / DATE OF BIRTH	E-MAIL ADDRESS	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
RACE / ETHNICITY / PREFERRED LANGUAGE		SOCIAL SECURITY #
PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE		HOME PHONE
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)		CELL/PAGER
EMPLOYER NAME/ADDRESS	OCCUPATION	BUSINESS PHONE
SPOUSE'S NAME	SPOUSE'S EMPLOYER	BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you)	RELATIONSHIP	PHONE
REFERRING DOCTOR/PRIMARY CARE DOCTOR	PHONE	

HAVE YOU BEEN TREATED BY DANIEL SINGER, MD PRIOR TO TODAY'S VISIT? ❑ YES ❑ NO - IF NO, PLEASE ANSWER BELOW

HOW DID YOU HEAR ABOUT US? ❑ FAMILY MEMBER ❑ FRIEND ❑ PHYSICIAN ❑ YELLOW PAGES ❑ WEBSITE ❑ GOOGLE ❑ EMPLOYER ❑ YELP ❑ INSURANCE ❑ SOCIAL NETWORK

If patient is a CHILD, please complete the following:

PARENT/GUARDIAN'S NAME	RELATIONSHIP TO PT	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
HOME PHONE / BUSINESS PHONE	CELL	CHILD'S SCHOOL (OPTIONAL)
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD		RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

❑ PRIVATE INSURANCE ❑ WORKER'S COMPENSATION **WE DO NOT TAKE NO-FAULT & THIRD PARTY LIABILITY INSURANCE**

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐ M ☐ F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #	GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐ M ☐ F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #	GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐ M ☐ F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #	GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITIONS WE ARE TREATING YOU FOR TODAY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize Daniel Singer, MD or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier. _____ (initial here)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Details of your rights and how your medical information will be used and disclosed by Daniel Singer, MD is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been given to you and is posted in the clinic area and company website. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. _____ (initial here)

FINANCIAL AGREEMENT

I have read and agree with all financial policies. I understand that I am financially responsible for all charges whether or not paid by said insurance_____ (initial here)

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature _____ Relationship to Patient _____ Date _____

Daniel I Singer MD Inc.
1401 S Beretania St #720
Honolulu, HI 96814

Welcome to Daniel I Singer MD Inc. Please read the following carefully. Please feel free to speak to any of our Patient Service Representatives if you have any questions. Thank you for choosing Daniel Singer, MD.

Acknowledgements and Consents

Consent for Purposes of Treatment, Payment, and Healthcare Operations-
I hereby give my consent to Daniel I Singer MD Inc. to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in my patient record.

I understand that Daniel I Singer MD Inc. reserves the right to change its privacy practices that are described in the notice. I also understand that any revised notice will be posted on Daniel I Singer MD Inc.'s website, available at each office, or I may request a copy be sent to me by mail.

Insurance Policies

No Insurance-
If you do not have any insurance coverage, payment will be due at the time of service.

Insurance-
Please bring your current insurance cards to all appointments. We will file a claim to all carriers where we have a contractual obligation to do so. We must emphasize that as health care providers, our relationship is with you, not your insurance company, and all charges are your responsibility from the date services are rendered. You are responsible for any co-insurance, deductibles, co-payments and/or non-covered services as required by your insurance.

Third-Party Liability-
Third party Liability：We do not take/ participate in these cases.
No-Fault: We do not take/ participate in these cases.
If you initially seek treatment under your private insurance and subsequently notify our office that a NF or TPL claim has been filed, you will be required to find another physician for further treatment.

Workers' Compensation-
If your injury is due to an accident at your work place, we must have approval from your adjuster prior to seeing you. Failure to properly report this injury to your employer may result in your claims denied. Denied claims will be your responsibility.

HMO/Managed Care Plans-

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If you belong to an insurance that requires a referral from your primary care physician, please bring the referral with you. Any services received without a referral or prior authorization will be your responsibility. If you present to our office without a referral, we reserve the right to reschedule your appointment.

Office Policies

Appointments-
Office visits to see our physician are by appointment only. Every effort will be made to accommodate your preferred date and time. Emergencies will always be given priority and our nurses will try to contact you if there is a delay or your physician has been called out.

Cancelled Appointments/No Shows-
If you are unable to keep your scheduled appointment, please contact our office at least 24 hours prior to your appointment so that we may use that time to see another patient in need of our services. Please note that a $35.00 Cancellation/No Show Fee may be billed to you, which is NOT payable by your insurance, for any missed appointments if proper notification has not been given.

After Hours Contact-
In the event of an emergency, please go directly to the nearest emergency room. Dr. Daniel Singer can also be reached through the Physicians Exchange at 808-524-2575.

Prescription Refills-
Please request all prescription refills during normal office hours when your medical records are available for review. Prescription request after hours or weekends will only be considered under emergent circumstances.

Disability or Insurance Forms-
There will be a charge of $25.00 for the completion of medical forms. You will be called once the forms are completed, and they can be picked up at our office. Payment is due at the time you pick up the forms. If you would like the forms mailed to you, payment must be received prior to mailing.

Financial Policies

Patient Financial Responsibility-
I acknowledge full financial responsibility for services rendered by Daniel I Singer MD Inc. I understand that I am responsible for prompt payment of any charges, including co-pays, deductibles, co-insurance amounts, and/or non-covered benefits. I understand that payment of co-pays, deductibles, and co-insurance amounts are expected at time of service, as well as any prior balance due that I may owe Daniel I Singer MD Inc. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to Daniel I Singer MD Inc. for any medical or surgical services rendered.

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Returned Checks-
A fee of $25.00 will be charge to your account for any checks returned by your bank for any reason, in addition to any fees that your financial institution may charge you directly.

I have read the Daniel I Singer MD Inc. Acknowledgement & Consents, Insurance, Office, and Financial Policies. I agree to abide by all polices as written.

_____	_____	_____
Patient/Parent/Guardian Signature	Patient/Parent/Guardian-Print Name	Date

Name:
Acct #:
Date:

Daniel I. Singer MD - Patient Health History Form

Please print legibly

Exam RM #_____
Office use only

Date: _____

NP EN Last Seen_____
Films _____
PVT WC
INS CO_____
DOI_____
EMP_____
Work Status:_____
off sed lt mod reg

Name_____
Age _____ Gender- M F

Primary Care Physician_____
Referred by_____

HAND-FINGERS-ELBOW-ARM

HISTORY OF PRESENT ILLNESS/PROBLEM - Circle appropriate answers that apply to your appointment

1. Location of problem? Hand Wrist Elbow Finger(s) Thumb - Index - Middle - Ring - Pinky
   Other area, describe - _____

2. Which side? Left Right Both **If both**, which side is worse? Left Right

   What part is bothering you? Front Back Side Joint All over Other_____

3. Description of your symptoms - Pain - Sharp Dull Burning Weakness Swelling
   Stiffness Clicking Catching Locking Numbness Lump

   Other symptoms not listed - _____

4. When did symptoms start? (Date of onset) _____

5. How did symptoms/condition start? _____

6. Where did it happen or where were you when you noticed the problem? _____

7. Severity or intensity of pain? Circle number -

   0 1 2 3 4 5 6 7 8 9 10
   None Mild Moderate Severe

8. Frequency of symptoms- Constant Intermittent Morning Night With Activity

   Other not listed - _____

9. Medications taken for this condition? Oral _____ Injections, how many? _____

_____ _____ _____
Patient/Parent/Guardian Signature Relationship to Patient Date

Name:
Acct #:
Date:

HEALTH HISTORY FORM - PFSH

DOB:_____ M / F Height:_____ Weight:_____ BMI:_____ R / L Handed Occupation:_____

Please list any **ALLERGIES** or **REACTIONS** to **Latex, Iodine, Metal** or any **Medication**. ☐ I have none of these allergies.

1. 3. 5.
2. 4. 6.

List all **MEDICATIONS/Herbs/Vitamins and Supplements** that you are **currently taking**:

☐ Check Box if separate list has been provided 3. 6.
1. 4. 7.
2. 5. 8.

List all **SURGERIES** that you have had **with approximate dates** of each surgery:

1. 3. 5.
2. 4. 6.

MEDICAL HISTORY

	NO	YES		NO	YES
High Blood Pressure	____	____	Asthma/Emphysema	____	____
Heart Attack/Coronary Artery Disease	____	____	Bleeding Disorder/Anemia	____	____
Irregular Heart Beat	____	____ If yes, do you have a **Pacemaker**? Yes / No	Intestinal Bleeding/Ulcer	____	____
Stroke/Paralysis	____	____	**Hypo**thyroid	____	____
Blood Clots/Pulmonary Embolism	____	____	**Hyper**thyroid	____	____
Diabetes	____	____	Seizures	____	____
Kidney Failure/Disease	____	____ If yes, are you on **Dialysis**? Yes / No	TB	____	____
Rheumatologic Condition	____	____	Reaction to Anesthesia	____	____
Hepatitis/Liver Disease/HIV	____	____			
MRSA	____	____	Other:_____		
Cancer	____	____ If yes, Type of Cancer/Description:_____			

FAMILY HISTORY

	NO	YES		NO	YES		NO	YES		NO	YES		NO	YES
Stroke	___	___	Heart Attack	___	___	Diabetes	___	___	Reaction to Anesthesia	___	___	Bleeding Disorder or Anemia	___	___	Cancer	___	___ Type:_____

SYSTEMS REVIEW - Have you **recently** had problems with any of the following?

	NO	YES	DESCRIPTION (**If Yes**, provide a description and indicate if condition is resolved)
Cold/Flu	____	____	_____
Eye/Ear	____	____	_____
Intestinal	____	____	_____
Heart	____	____	_____
Breathing	____	____	_____
Skin	____	____	_____
Nerve	____	____	_____
Urinary	____	____	_____
Bleeding	____	____	_____
Depression/Anxiety	____	____	_____

SOCIAL HISTORY

Do you **SMOKE**? ____**NEVER DID** or ____**QUIT**, I have not smoked since: _____ or ____**YES**, I smoke _____cigarettes per day
Do you use **RECREATIONAL DRUGS** (including Marijuana)? ____**NO** or ____**YES**
Do you drink **ALCOHOL?** ____**NO** or ____**YES**, number of drinks per day_____, week_____, month_____
What sport(s) do you participate in or activities do you do for **EXERCISE**? _____

High School Attended:_____ College Attended:_____