HEALTHY ASIANS
& PACIFIC ISLANDERS
MEDICAL CENTER

PATIENT INFORMATION

LAST NAME: FIRST NAME: MIDDLE:

DATE OF BIRTH: SOCIAL SECURITY #:

ADDRESS:

CITY: STATE: ZIP:

☐ MALE ☐ FEMALE SINGLE MARRIED DIVORCED SEPARATED WIDOWED

PREFERRED PRONOUNS: ☐ He/Him ☐ She/Her ☐ They/Them/Their ☐ Other

HOME PH: CELL PH: EMAIL:

PREFERRED METHOD OF CONTACT: ☐ TEXT ☐ EMAIL ☐ PHONE

PHARMACY (please include cross streets):

EMERGENCY CONTACT: RELATIONSHIP: PH:

REFERRED BY:

EMPLOYER: OCCUPATION: (Or prior occupation)

EMPLOYER'S ADDRESS: RETIRED: ☐ YES ☐ NO

CITY: STATE: ZIP: WORK PH:

WORK RELATED INJURY: ☐ YES ☐ NO AUTOMOBILE ACCIDENT: ☐ YES ☐ NO DATE OF ACCIDENT:

ADVANCED DIRECTIVE: ☐ YES ☐ NO COPY ON FILE: ☐ YES ☐ NO

IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION – Primary Insurance

PRIMARY INSURANCE:

INSURED NAME: PHONE:

DATE OF BIRTH: SOCIAL SECURITY #:

GROUP #: POLICY #:

ADDITIONAL DETAIL

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ OTHER RACE: _____ ☐ PREFER NOT TO SAY

WHAT IS YOUR ETHNICITY/COUNTRY OF ORIGIN? _____

LANGUAGE SPOKEN AT HOME: _____ PREFERRED LANGUAGE: _____

HOW DID YOU HEAR ABOUT US? ☐ FAMILY AND FRIENDS ☐ SOCIAL MEDIA ☐ RADIO ☐ NEWSPAPER ☐ EVENTS

☐ BROCHURE/FLYER ☐ WEBSITE ☐ OTHER: _____

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AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency to include but not limited to, commissions, attorney & court filing fees, or interest rates assigned by collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

SIGNATURE: _____ DATE: _____

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PATIENT HEALTH QUESTIONNAIRE

ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES

MEDICATION NAME:	REACTION:

CURRENT MEDICATION/SUPPLEMENTS: *List all prescription medications you are **CURRENTLY** taking.*

MEDICATION NAME:	DOSE	FREQUENCY	WHEN YOU STARTED

PAST MEDICAL HISTORY: *Please circle all that apply*

CARDIAC	**BLOOD/CANCER**	**OB/GYN**	**SKIN**
Heart Attack	Anemia	Breast Tumor/Cancer	Eczema
High Cholesterol	Cancer/Tumors	Still births	Psoriasis
High Blood Pressure	Blood Transfusions	Difficulty Conceiving	Skin cancer
Irregular Heartbeat	Radiation Therapy	Heavy/Irrg Periods	
Heart Failure	Chemotherapy	Menopause	

RESPIRATORY:	**NEUROLOGICAL**	**ENDOCRINE**	**HEENT**
COPD/Emphysema	Convulsions, Seizures	Diabetes Type I, Type II	Cataract
Asthma	Stroke	Thyroid Disorder	Glaucoma
Pneumonia	Headaches	Osteoporosis	Nasal polyps
Seasonal Allergies	Migraines		Recurrent ear infections
Tuberculosis	Neuropathy		

DIGESTIVE	**MOOD**	**URINARY**	**RHEUMATOLOGY**
Heart burn	Depression	Chronic Kidney disease	Gout
Hernia	Anxiety	Kidney Infection	Joint pain
Duodenal/Gastric Ulcer	Phobias, Panic	Kidney Stones	Rheumatoid Arthritis
Ulcerative Colitis/Crohns	Drug/Alcohol problem	Bladder/Kidney cancer	Osteoarthritis
Diverticulosis/Diverticulitis		Recurrent UTI	Lupus
Hepatitis A, B, C		Urinary Incontinence	

PLEASE LIST ANY OTHER CONDITIONS YOU HAVE:	

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PAST HOSPITALIZATION/SURGICAL HISTORY: *List all surgery or hospital admission that you have had.*

SURGERY *(specify left. right)* / ADMISSION REASON	HOSPITAL / STATE	DATE / YEAR

FAMILY HISTORY: *Please give the following information about the health of your **IMMEDIATE** family*

RELATION	AGE IF ALIVE	AGE AT DEATH	HEALTH STATUS/ CAUSE OF DEATH
MOTHER			
FATHER			
SIBLING 1 ☐ brother ☐ sister			
SIBLING 2 ☐ brother ☐ sister			
SIBLING 3 ☐ brother ☐ sister			

*HAVE ANY OF THE **ABOVE** RELATIVES EVER HAD ANY OF THE FOLLOWING: (IF SO, INDICATE RELATIONSHIP)*

ABNORMAL BLEEDING / CLOTTING	☐	WHO:
ALCOHOLISM	☐	WHO:
ALZHEIMER'S / DEMENTIA	☐	WHO:
CANCER: please indicate type _____	☐	WHO:
DIABETES	☐	WHO:
HEART ATTACK	☐	WHO:
HIGH BLOOD PRESSURE	☐	WHO:
HIGH CHOLESTEROL	☐	WHO:
KIDNEY DISEASE	☐	WHO:
MIGRAINES	☐	WHO:
PSYCHIATRIC DISEASE / SUICIDE	☐	WHO:
SEIZURES / EPILEPSY	☐	WHO:
THYROID DISORDER	☐	WHO:

PREVENTATIVE CARE:	date of last:	IMMUNIZATIONS:	date of last:
PAP SMEAR		FLU	
MAMMOGRAM		TETANUS *(every 10yrs)*	
BONE DENSITY SCAN		PPD *(Tuberculosis)*	
COLONOSCOPY		PNEUMOVAX *(pneumonia)*	
PSA *(prostate)*		SHINGRIX *(shingles)*	
CT CHEST *(lung cancer)*		HPV *(human papilloma virus)*	
ABDOMINAL US		COVID	☐ Pfizer ☐ Moderna ☐ J&J

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SOCIAL HISTORY:

TOBACCO USE: Smoke Cigarettes? ☐ Yes ☐ No *(If you NEVER smoked, please move on to Alcohol/Drug use)*

CURRENT: packs/day _____ # of yrs _____

PAST: packs/day _____ # of yrs _____ QUIT DATE: _____

Other Tobacco products: ☐ Pipe ☐ Cigar ☐ Chew ☐ Vape Would you like to quit today? ☐ Yes ☐ No

ALCOHOL/DRUG USE: Do you drink alcohol? ☐ Yes ☐ No Type consumed? ☐ Wine ☐ Beer ☐ Liquor

How much do you consume? _____ ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Have you ever used needles to inject drugs? ☐ Yes ☐ No

Do you use marijuana or recreational drugs? ☐ Yes ☐ No

SEXUAL HISTORY: Sexually involved currently? ☐ Yes ☐ No *(If no sexual history, please continue to exercise)*

Sexual partner(s) is/are/have been: ☐ Male ☐ Female How many partners in the last year? _____

Birth control method: ☐ None ☐ Condom ☐ Pill / Ring / Patch / Depo ☐ IUD/Implant ☐ Vasectomy

EXERCISE: Do you exercise regularly? ☐ Yes ☐ No Type of exercise? _____

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____ days/wk

On those days that you engage in moderate/strenuous exercise, how many minutes (avg) do you exercise? _____ mins

DIET: How would you rate your diet? ☐ Good ☐ Fair ☐ Poor How is your appetite? ☐ Good ☐ Fair ☐ Poor

Caffeine use? ☐ Yes ☐ No If yes, what kind of caffeine do you consume, how much, and how often?

(e.g. coffee 1 cup/a day, tea, soda or others): _____

Are there foods you avoid/limit due to health reasons? *(please specify)*: _____

FEMALES:

LAST MENSTRUAL CYCLE: _____/_____/_____

AGE OF FIRST MENSTRUATION: _____ AGE OF MENOPAUSE: _____

PREGNANCIES _____ LIVE BIRTHS _____ MISCARRIAGES _____ ABORTIONS _____

DELIVERY TYPE: ☐ Vaginal ☐ C-Section

PREGNANCY COMPLICATIONS: _____

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AUDIT–C QUESTIONNAIRE

1. *HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST 12 MONTHS?*	☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week
2. *HOW MANY STANDARD DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST 12 MONTHS?*	☐ 0 drinks *(did not drink in the past 12mo)* ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more
3. *HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION IN THE PAST 12 MONTHS?*	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

PHQ–2 QUESTIONNAIRE

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	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

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REVIEW OF SYSTEMS

Please ✓ ALL that you have experienced within the PAST WEEK or associated with your current illness

CONSTITUTIONAL	GASTROINTESTINAL	NEUROLOGICAL
Fever	Abdominal pain	Headache
Chills	Abdominal distension	Dizziness
Sweats	Nausea	Light-headedness
Fatigue	Vomiting / Vomiting blood	Tremor
Unexpected weight change	Painful swallowing	Numbness
Sleep disturbances	Diarrhea	Disorientation
Appetite change	Constipation	Unsteady
HEAD, EYES, EARS, NOSE, THROAT	Change in stool	Speech difficulty
Congestion	Heartburn	Fainting (Syncope)
Ear discharge	Rectal pain / Anal bleeding	Burning sensation
Ear pain	Black tarry stool	Seizures
Hearing loss	Yellow skin	Poor coordination
Runny nose	Bowel incontinence	Decreased strength
Nosebleed	**GENITOURINARY**	Memory loss/lapses
Sore throat	Painful urination	**PSYCHIATRIC**
Ringing in ears	Frequent urination	Depression
Snoring	Incontinence	Anxiety
Hoarseness	Difficulty urinating	Hallucinations
Vision change	Blood in urine	Suicidal ideas
Eye discharge	Penile discharge	Self-injury
Itchy eyes	Penile pain	Hyperactive
Eye pain	Scrotal swelling	**HEMATOLOGIC**
Eye redness	Testicular pain	Easy bruising
CARDIOVASCULAR	Genital itching	Easy bleeding
Chest pain	**WOMEN'S HEALTH**	Swollen lymph nodes
Irregular heartbeat	Pelvic pain	**SKIN**
Palpitations	Abnormal vaginal bleeding	Rash
Leg swelling	Heavy periods	Skin Wound
Leg pain with walking	Pain with intercourse	Unusual growth
Cold extremities	Vaginal discharge	Change in mole
RESPIRATORY	**MUSCULOSKELETAL**	Itching
Shortness of breath	Neck pain	**ENDOCRINE**
Cough	Neck stiffness	Excessive thirst
Wheezing	Back pain	Excessive urination
Coughing up blood	Joint pain	Heat intolerance
Coughing up sputum	Limb pain	Cold intolerance
Chest tightness	Joint swelling	Hair changes
Rapid breathing	Leg swelling	Skin changes
	Muscle cramps	
	Muscle pain	
	Muscle weakness	

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RELEASE OF MEDICAL RECORDS AUTHORIZATION

If any, please provide your previous PCP's office to transfer patient medical records to HAPI.

PATIENT NAME: _____ DATE OF BIRTH: _____

I HEREBY AUTHORIZE:

OFFICE: _____ PH: _____

ADDRESS: _____ FAX: _____

TO DISCLOSE THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

- ☐ ENTIRE MEDICAL RECORD
- ☐ CLINICAL NOTES
- ☐ MEDICATION LIST
- ☐ CONSULT NOTES
- ☐ LABORATORY RESULTS
- ☐ IMAGING RESULTS
- ☐ OTHER: _____

THE INFORMATION WILL BE DISCLOSED TO:

HEALTHY ASIANS
& PACIFIC ISLANDERS
MEDICAL CENTER

8863 W Flamingo Rd Suite 101

Las Vegas NV 89147

Ph: 702-485-3888

Fax: 725-299-1115

SIGNATURE: _____ DATE: _____

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ADVANCE DIRECTIVES

(To keep a copy of your Advance Directive in your chart is OPTIONAL)

For patients 18 and older:

Advanced care planning refers to a process of mapping out the types of medical and non-medical care you would like to receive at some future point should a life-threatening or terminal disease make it impossible for you to express your wishes at that time. While this conversation results in a document, it is more than just a piece of paper. It is an effort to better educate you about alternatives regarding the end-of-life and an opportunity to educate physicians, spouse, family and others about your values, goals and wishes related to end-of-life care. This communication between you and your provider can be done at any time; preferably when you are younger and still healthy. Once completed, it should be revised on a regular basis (every 5 years or after any potentially life-changing event, such as a marriage, divorce, death of a spouse, or the onset of a life-threatening disease)

An Advance directive is a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness or injury. It allows you to spell out your decisions about end-of-life care ahead of time and give you a way to tell your wishes to your family, friends and health care professionals to avoid confusion. It may also give a person (such as a spouse, relative or friend) the authority to make medical decisions for another person when that person can no longer make decisions. There are different types of advance directives, including a living will, durable power of attorney (DPA) for healthcare, and do not resuscitate (DNR) orders.

You might want to include instructions on

- The use of dialysis and breathing machines
- If you want to be resuscitated if your breathing or heartbeat stops
- Tube feedings
- Organ or tissue donation

PLEASE CHECK ONE OF THE STATEMENTS AND SIGN BELOW:

☐ I have an Advance Directive in effect

☐ I do NOT have an Advance Directive in effect currently. I have read and understand the above information on Advance Directives

SIGNATURE: _____ DATE: _____

PATIENT NOTIFICATION FORM

I have been given the information regarding the choices I can make regarding my health care. These choices are called Advance Directives, a Living Will, and or Durable Power of Attorney. I understand that for these directives to be valid, I will need to put them in writing and have them witnessed and or notarized. If I choose to make this part of my medical records, I will bring in a copy to the office to be included in my medical records.

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

HEALTHY ASIANS
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ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center and Patient herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient's Personal Health Information ("PHI"). The Patient agrees to inform the Practice of any changes to Patient's authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient's privacy and takes security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or causes by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practice's, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, an may lead to the termination of the Patient's agreement for Practice services.
8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronics information. However, the Patient's PHR Support subscription fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive) the Practice's actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment, but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT FOR AGREEMENT FOR PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the Practice's Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE WITH HIPAA

I _____, understand that as a part of my health care, HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or 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 a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- 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 HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to HAPI Medical Center DBA Healthy Asian and Pacific Islander Medical Center to disclose my protected healthcare information to the following person and/or people:

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

I fully understand and accept the terms of this consent

X _____ _____

PATIENT / LEGAL GUARDIAN SIGNATURE: DATE: