



INTEGRATIVE HEALTHCARE GROUP & REHABILITATION CENTER
PREVENTIVE & OCCUPATIONAL MEDICINE
INTEGRATIVE & PRIMARY CARE

932 Ward Ave., 6th floor, Honolulu, Hawaii, 96814 | ph. (808) 535-5555 fax (808) 535-5556 Phys. Ext. (808) 524-2575

Please provide the following information completely to the best of your ability so that we can provide you with the best service possible in all aspects of your treatment at our facility. Thank you.

PERSONAL INFORMATION

Date _____

Last Name _____ M.I. ____ First Name _____

Address _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Email address _____ Email address #2 _____

SS # _____ Occupation _____ Employer _____

Male Female (circle one) Date of Birth _____ Marital Status _____

Spouse's Name _____ Phone # _____

Nearest Relative _____ Phone # _____

Primary Dr. _____ Referred By _____

How did you hear about us? _____

INSURANCE INFORMATION

Private Insurance _____ Policy # _____ Group # _____

Subscriber Name _____ Date of Birth _____

Relationship to Patient _____ SS# _____

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber Name _____ Date of Birth _____

Relationship to Patient _____ SS# _____

Injury Insurance _____ W/C _____ N/F _____

Address _____ Date of Injury _____

Claim # _____ Adjuster _____ Phone # _____ Ext. _____

Attorney Name _____ Phone # _____

CONSENT TO TREATMENT OF MINOR

I hereby authorize Ira D. Zunin, M.D., M.P.H., and whomever he may designate to administer treatment as he so deems necessary to _____ Date of Birth _____.

SS # _____ Circle One- M F

Parent or Guardian Signature _____
Date

MEDICAL INFORMATION RELEASE

I hereby authorize Ira D. Zunin, M.D., M.P.H., and / or staff to release my confidential medical information to the following:

Name _____ Relationship _____ Phone # _____

MEDICATIONS DISCLOSURE

I, _____ understand that my physician has the ability to provide me with the medications that I may need for my treatment. I also understand that I will always be given the choice to receive a written prescription that I may fill at a pharmacy of my choosing.

Name _____ Signature _____ Date _____

CHIEF COMPLAINT

What is your chief complaint? _____

Is this condition due to an: (Circle one) Auto accident Work injury Other accident Unknown cause Illness

Symptoms are (Circle one) Improving Getting worse About the same Come & go * Date symptoms appeared _____

Have you had these symptoms before? If so, when? _____ How ? _____

Circle activities that aggravate condition: Standing Walking Sitting Lying Bending Lifting Twisting Coughing

Have you seen another health care practitioner for this condition? If so, who?

Name _____ Date _____ Diagnosis _____

OTHER AREAS OF CONCERN/INTEREST (“I am concerned about...” or “I would like to know more about...”)
(Check off 1 or more areas)

- | | |
|--|--|
| <input type="checkbox"/> Weight loss & nutrition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Smoking cessation | <input type="checkbox"/> Tension headaches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Post stroke treatment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Post surgery treatment & general rehabilitation |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sports preparation & rehabilitation |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Repetitive injuries (ex. Carpel Tunnel) | <input type="checkbox"/> Other areas: _____ |

I understand and agree that health and accident insurance policies are in agreement between an insurance carrier and myself. I authorize payment from my insurance carrier to be sent directly to this office with the understanding that all monies will be credited to my account upon receipt. However I clearly understand and agree that monies rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care that fees for my professional services rendered to me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with any collection cost and reasonable attorney fees as may be required to effect collection. I also understand that if I do not show up for a scheduled appointment I may be personally charged a \$50 fee.

Signature _____ Date _____

HAWAII PRIVACY OF HEALTH CARE INFORMATION LAW

MANAKAI O MANAMA INTEGRATIVE HEALTH CARE GROUP

In accordance with the American Medical Association Code of Ethics, we believe that the patient-physician relationship is based on trust and 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 our staff and us. We 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.

- Our office staff has received education and training regarding the use and handling of patients protected health information.
- Your records are secured in this office.
- Access to office keys is limited to our doctors, staff, and bonded cleaning crew.
- Access to electronic information is only released as required or permitted by state or federal law.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Manakai O Manama Integrative
(Patient, parent or legal guardian)

Healthcare Group to disclose health information, including copies or summaries of
medical records for _____ to:

(Name of patient)

- a. Any health insurance plan or company that provides insurance coverage for the purpose of payment of charges,
- b. Any insurance company that provides liability insurance coverage for Dr. Ira Zunin for the purpose of evaluating the treatment rendered or
- c. To health care providers to whom have referred the patient to this office for care, for the purposes of coordination of medical care.

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.

Signed: _____

Date: _____



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Dear patient,

We would like to thank you for your confidence in and support of our clinic, and the emerging field of integrative healthcare. It is your support and commitment that has allowed us to flourish and to provide you, and our community with the highest quality integrative healthcare. We hope that Manakai O Malama will continue to be your partner in health for years to come.

We are always looking at ways to improve our performance, and welcome your feedback as a way to direct our efforts.

We would like to take this opportunity to review our cancellation policy. Your scheduled visits are a crucial part of your treatment plan and recovery process. Your individual treatment plan is also designed for your maximum benefit. By missing an appointment or by arriving late and reducing your treatment time you may interrupt the healing process. We do understand that the unexpected happens, and that injury or illness may cause forgetfulness, ‘bad days’ etc. To come for treatment may be the best antidote for those bad days. We ask your consideration of the following simple guidelines:

- ❖ **Late Arrival** – Please call if you expect to arrive more than 10 minutes late for an appointment. Our practitioners will do their best to accommodate you if they can do so without disrupting another patients’ care.
- ❖ **Appointment Cancellations** – If you need to cancel an appointment, please give us 24-48 hours notice. This allows us to reassign that time slot, and reschedule your treatment as needed.
- ❖ **Missed Appointments** – When you realize that you have missed an appointment, please call to reschedule right away. If you miss 3 appointments without cause or notification we do reserve the right to suspend your treatment.

By abiding by these guidelines you can help us maximize our efficiency and your service delivery. On our part, we will continue to make every effort to stay on schedule, to ensure wait times are short, and to offer you the highest quality healthcare.

Mahalo from all of us at Manakai O Malama

I have read the above and agree to make every effort to abide by these guidelines in the future.

Patient name: _____

Patient signature: _____

Date: _____

MANAKAI O MALAMA

Patient Review of Systems

NAME: _____ DATE: _____

Please check if you have experienced any of the following:

GENERAL	YES	NO	YEAR	EXPLANATION
Fever				
Chills				
Weight Loss				
Weight Gain				
Trouble Sleeping				
Loss of Appetite				
HEENT	YES	NO	YEAR	EXPLANATION
Eye Pain				
Eye Redness				
Double Vision				
Loss of Vision				
Blurred Vision				
Ear Pain				
Hearing Loss				
Ear Drainage				
Swallowing Pain				
CVS	YES	NO	YEAR	EXPLANATION
Chest Pain				
Palpitations				
Poor Circulation				
RESPIRATORY	YES	NO	YEAR	EXPLANATION
Shortness of Breath				
Cough				
Breathing Discomfort				
Blood in Sputum				
GI	YES	NO	YEAR	EXPLANATION
Abdominal Pain				
Heartburn				
Vomiting				
Bloating				
Black/Bloody Stools				
Loose Stools				
GU	YES	NO	YEAR	EXPLANATION
Pain with Urination				
Difficulty Urinating				
Blood in Urine				
Excessive Urination				
Urgent Urination				
Frequent Urination				

EXTREMITIES	YES	NO	YEAR	EXPLANATION
Neck Pain				
Stiff Neck				
Back Pain				
Muscle Aches				
Swollen Joints				
Muscle Stiffness				
Joint Stiffness				
SKIN	YES	NO	YEAR	EXPLANATION
Rash				
Boils				
Lesions/Moles				
Sun Sensitivity				
NEUROLOGICAL	YES	NO	YEAR	EXPLANATION
Tingling				
Poor Balance				
Dizziness				
Speech Difficulty				
Swallow Difficulty				
Weakness				
PSYCHIATRIC	YES	NO	YEAR	EXPLANATION
Depression				
Anxiety				
Fear				
Loss of Interest				
Behavior Change				