SAKAMOTO
DERMATOLOGY

WWW.SAKAMOTODERMATOLOGY.COM
Queens Physicians Office Building III
550 S. Beretania St. Suite 603, Honolulu, HI 96813
Office: (808) 447-7454 · Fax (808) 447-7456

Patient Registration Form

Last Name:_____ First Name:_____ M.I.:_____

Date of Birth:_____ Gender: ☐ Male ☐ Female SS#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home #:_____ Work #:_____ Mobile #:_____

Preferred Daytime Phone: ☐ Home ☐ Work ☐ Mobile / Ok to leave a message: ☐ Yes ☐ No

******Selecting "YES" allows the office to leave a message regarding sensitive medical information on your voicemail, such as lab/pathology results, etc.***

Preferred Language: ☐ English ☐ Other:_____

E-Mail Address:_____

******NOTE: Patient Portal Access is set up via email - you will be able to participate with on-line billing, appointment requests, telehealth visits, etc.***

Emergency Contact: (Limited information will be provided to persons' listed below in the event of an emergency within our office.)

Name:_____ Relationship to patient:_____ Contact #:_____

Name:_____ Relationship to patient:_____ Contact #:_____

Financially Responsible Party

In accordance with Greg K. Sakamoto, M.D. Financial Policy, this is defined as the adult accompanying a **child under the age of 18**, and/or the parent or guardian of the child or persons that is medically incapacitated. This is the person who will receive bills and correspondence. Co-payments/Outstanding Balances are **due and expected** at the time of service.

Financially Responsible Parent/Guardian: Last Name:_____ First Name:_____

Relationship to Patient: ☐ Mother ☐ Father ☐ Other:_____

Date of Birth:_____ Gender: ☐ Male ☐ Female

Home #:_____ Work #:_____ Mobile #:_____

Address: ☐ Same as Above / Other: _____ City/State/Zip:_____

Insurance Information

In order for Greg K. Sakamoto, M.D. office to file a claim on your behalf, this section must be completed and a valid insurance card is required upon check-in.

☐ **No Insurance/Self Pay**

Primary Insurance:_____ Subscriber Name:_____

Subscriber Date of Birth:_____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Policy #:_____ Group #:_____

Secondary Insurance:_____ Subscriber Name:_____

Subscriber Date of Birth:_____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Policy #:_____ Group #:_____

My signature below indicates that I have received, reviewed, and agreed to the policies set forth on the forms titled: (1) *Financial and Office Policies*, and (2) *Notice of Privacy Practices*. I attest that this form is accurate and complete to the best of my knowledge. I hereby authorize the release of any medical information necessary to process claims pertinent to my care with Greg K. Sakamoto, MD and I authorize my insurance benefits to be paid directly to this practice and acknowledge that I am financially responsible for any unpaid balance.

Responsible Party Signature:_____ Date:_____

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Patient Medical History (1 of 2)

Patient Name:_____ Date of Birth:_____

Reason for your visit:_____

Primary Care Physician:_____

Preferred Pharmacy:_____(Prescriptions will be e-faxed to the pharmacy listed)

Authorize healthcare information to be discussed with household member(s)? ☐ Yes ☐ No

******Selecting "YES" allows the office to discuss any and all medical information with the persons listed below, such as lab/pathology results, medications, etc. This does not apply to minor(s) 0-17 years of age, unless otherwise specified (e.g. TRO's, Custody Agreements) or for other persons besides parents/legal guardians.***

If yes, please inform us of who: Name:_____ Relationship:_____ Contact #:_____

Name:_____ Relationship:_____ Contact #:_____

Medical History: (Please **CHECK** all that apply) ☐ **NONE** / Current Height: _____ Current Weight:_____

☐ Anxiety	☐ Diabetes Mellitus	☐ High Cholesterol	☐ Malignant tumor of Colon
☐ Arthritis	☐ Disease related by COVID	☐ Hyperthyroidism	☐ Malignant tumor of Prostate
☐ Asthma	☐ Elevated Blood Pressure	☐ Hypothyroidism	☐ Transplant of Bone Marrow
☐ Atrial Fibrillation	☐ End Stage Renal Disease	☐ Inflammatory Disease of Liver	☐ Radiation Therapy
☐ Benign Prostatic Hyperplasia	☐ Epilepsy	☐ Leukemia	
☐ Cerebrovascular Accident (Stroke)	☐ GERD	☐ Malignant Lymphoma	
☐ Coronary Arteriosclerosis	☐ Hearing Loss	☐ Malignant tumor of Lung(s)	
☐ Depressive Disorder	☐ HIV	☐ Malignant tumor of Breast	

Other:_____

Past Surgeries: (Please **CHECK** all that apply) ☐ **NONE**

☐ Abdominal resection	☐ H/O bilateral mastectomy	☐ Lumpectomy of right breast	☐ Total orchiectomy
☐ Bilateral replacement of knee joints	☐ H/O cholecystectomy	☐ Mastectomy of left breast	☐ Left hip replacement
☐ Biopsy of breast	☐ H/O colectomy	☐ Mastectomy of right breast	☐ Left knee replacement
☐ Biopsy of prostate	☐ H/O liver excision	☐ Mechanical heart valve replacement	☐ Right hip replacement
☐ Coronary artery bypass graft	☐ H/O coronary angioplasty	☐ Oophorectomy	☐ Right knee replacement
☐ Entire transplanted kidney	☐ H/O heart valve replacement	☐ Pancreatectomy	☐ Transplantation of heart
☐ Excision of basal cell carcinoma	☐ H/O cystectomy	☐ Kidney stone removal	☐ Transplantation of liver
☐ Excision of melanoma	☐ H/O transurethral prostatectomy	☐ Portosystemic shunt operation	
☐ Excision of squamous cell carcinoma	☐ Hysterectomy	☐ Prostatectomy	
☐ H/O colostomy	☐ Kidney biopsy	☐ Prosthetic arthroplasty of bilateral hips	
☐ H/O tubal ligation	☐ Low anterior resection of rectum	☐ Splenectomy	
☐ H/O appendectomy	☐ Lumpectomy of left breast	☐ Total nephrectomy	

Other:_____

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Patient Medical History (2 of 2)

Skin History: (Please **CHECK** all that apply) ☐ **NONE**

☐ Acne ☐ Blistering Sunburns ☐ Flaking/Itchy Scalp ☐ Squamous Cell Carcinoma

☐ Actinic Keratosis ☐ Dry Skin ☐ Melanoma (If selected, Date(s)?: _____)

☐ Basal Cell Carcinoma ☐ Eczema ☐ Psoriasis

Family history of Melanoma? ☐ Yes ☐ No If YES, which relative(s)?:_____
Skin Biopsies/Surgeries? ☐ Yes ☐ No If YES, location(s)?:_____
MOHs(Micrographic Surgery for Skin Cancer)**?** ☐ Yes ☐ No If YES, area(s)/provider?: _____
Do you wear sunscreen? ☐ Yes ☐ No If YES, SPF _____ ☐ Daily ☐ Occasionally
Do you use a tanning booth? ☐ Yes ☐ No If YES, often?: ☐ Weekly ☐ Monthly ☐ Other:_____
Autoimmune Diseases: ☐ Yes ☐ No If YES, type(s)?:_____
******Such as Rheumatoid Arthritis, Psoriatic Arthritis, Sjorgen's, Lupus, Diabetes Type 1, Addison's, Grave's, Multiple Sclerosis, Inflammatory Bowel (IBS), Hashimoto's.***

Medications: (Please list **ALL** current medications with **dosage/frequency**) ☐ **List Provided** ☐ **NONE**

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Allergies: (Please list **ALL allergies and reactions** experienced) ☐ **List Provided** ☐ **Seasonal ONLY** ☐ **NONE**

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

SOCIAL HISTORY

Cigarette Smoking: ☐ None ☐ Current ☐ Former : Quit Date:_____ ☐ Occasionally
Vaping: ☐ None ☐ Current ☐ Former : Quit Date:_____ ☐ Occasionally
Recreational Drug(s): ☐ None ☐ Current ☐ Former : Quit Date:_____ ☐ Occasionally
Alcohol Use: ☐ None ☐ Less than 1 drink/day ☐ 1-2 drinks/day ☐ 3 or more drinks/day
Born and Raised: _____
Employment: ☐ Not Applicable ☐ Self ☐ Retired ☐ Full-Time ☐ Part-Time **Occupation:**_____
Student: ☐ Not Applicable ☐ Full-Time ☐ Part-Time **School:**_____

Pregnant or planning to become pregnant: ☐ Yes ☐ No If **Pregnant**, how many weeks?:_____
Have you received your annual flu vaccination? ☐ Yes ☐ No If **YES**, when?:_____
Have you received a COVID vaccination? ☐ Yes ☐ No
Are you 65 or over? ☐ Yes ☐ No **(If "NO", no further questions)**
Have you received a pneumonia vaccination? ☐ Yes ☐ No
Do you have a health proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No
Which best reflects your wishes on advanced care recommendations?
☐ Do Not Intubate ☐ Do Not Resuscitate ☐ Full Cardiopulmonary Resuscitation

I attest that this form is accurate and complete to the best of my knowledge.

Patient/Parent/Guardian Signature:_____ **Date:**_____