Oahu Medical Group

Heath Chung M.D, Eric Kajioka M.D, James Joyner M.D, Benjamin Thomas M.D,
Lorrance Majewski D.O, John Raymond Go M.D
500 Ala Moana Blvd Building 5-300
Honolulu, HI 96813

Name: _____ Date of Birth: _____ ☐ M ☐ F

Address: _____

City: _____ State:_____ Zip code:_____

Phone: ( )_____

Email: _____

Marital Status: ☐ Single ☐Married ☐ Widowed Language: _____

Emergency Contacts:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name of person/doctor making referral:_____

Name of Primary Care Physician:_____

I authorize the release of confidential medical information to the following contact persons (family, friends, etc.):

Name: _____ Name: _____

Phone: ( ) _____ Phone: ( ) _____

Relationship: _____ Relationship: _____

Are you registered with **Queens MyChart**? ☐Yes ☐No

If not, please scan the QR code to get registered. MyChart allows you to request medication refills, message your doctor, request appointments, and more!

MyChart powered by Epic

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Do You Smoke? ☐ **No** ☐ **Yes** ☐ **Past – How long ago? _____**

Drug Allergies: ☐ **No** ☐ **Yes , If yes please list below**

Allergy	Reaction
1.	
2.	
3.	

Medications:

Name of Drug	Dose	How medication is taken
Example- Tylenol	***325mg***	***1-2 tablets every 4-6 hours***
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

*I authorize **Oahu Medical Group** to disclose/request my health information including copies of records as necessary to/from:*

1. *Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.*
3. *Any worker's compensation, no fault, or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end two (2) years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Signature of Patient/ Legal Guardian: _____ Date: _____