HI Coalition for Health Pediatric Clinic of Wahiawa
302 California Ave. Suite 209
Wahiawa, HI 96786

Newborn Follow-Up

Patient's Name: _____

Mother's Name: _____

DOB:_____Time of birth:_____

Gestational:_____Delivery:_____

Mother's blood type:_____

Birth Weight:_____

Discharge Weight: _____

Discharge date:_____

Hearing Evaluation: Left: P / F Right: P / F

Baby's blood type:_____

Bilirubin:_____

Hepatitis B:_____

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302 California Ave. Suite 209 Wahiawa, HI 96786
P: 808-622-2655 F: 808-829-3741

Date: ___/___/___

Patient Registration

Patient's Name: (Last)_____**(First)**_____**(Middle)**_____

Mailing Address:_____

City: _____**State:** _____**Zip:**_____**Country:** _____

Birth Date:___/___/___ **Cell:** _____ **Home:**_____

Contact By: Phone Paper Email **Email:** _____ **Sex:** Male / Female

SSN: _____ **Race:** Black Hispanic Native American Oriental/Asian White Other

Responsible Party:

Guardian's Name: (Last)_____**(First)**_____**(Middle)**_____

Mailing Address:_____

City: _____**State:** _____**Zip:**_____**Country:** _____

Birth Date:___/___/___ **Cell:** _____ **Work:**_____

Contact By: Phone Paper Email **Email:** _____ **Sex:** Male / Female

Just to inform you we will be doing confirmations by text/email. If you wish to be contacted by text/email please sign below.

X_____

Hawaii Coalition for Health
302 California Ave. Ste. 209
Wahiawa, HI 96786
Office: (808)622-2655 Fax: (808)829-3741

NEWBORN FOLLOW-UP

Name _____

Date of Birth ____/____/____

Hospital of Birth _____

Length ____ Weight ____lbs, ____oz.

Breastfed Y N Birth Rank ____

Gestational _____

Delivery _____

Neonatal _____

IMMUNIZATIONS in Hospital:	Date Given:
_____	____/____/____
_____	____/____/____
_____	____/____/____

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FOR: _____ **DOB:** _____

Patient Consent for Use and Disclosure of Health Information

I hereby give my consent for Hawaii Coalition for Health to use and disclose protected health information about me to carry out treatment, payment, and health care operations. (The Notice of Privacy Practices provided by Hawaii Coalition for Health describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hawaii Coalition for Health reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hawaii Coalition for Health office, 302 California Ave. Ste. 209 Wahiawa, HI 96786.

With this consent, Hawaii Coalition for Health may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Hawaii Coalition for Health may mail to my home or other alternative location any items that assist the practice in carrying out health care operation, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, Hawaii Coalition for Health may e-mail to my home or other alternative location any items that assist in carrying out health care operations, such as appointment reminders and patient statements.

I have the right to request that Hawaii Coalition for Health restrict how it uses or discloses my personal health information to carry out health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to allow Hawaii Coalition for Health to use and disclose my personal health information to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Hawaii Coalition for Health may decline to provide treatment to me.

Signed by: _____ Date: _____

Relationship to Patient: _____