HAWAI'I UTELEHEALTH

# Registration Form

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|---|
| Preferred name (first and last) and pronouns (ex. she, he, they) |
| |
| Legal name (if different from preferred) |
| |
| Date of birth |
| |
| Sex/gender (ex. female, intersex, male, nonbinary, transgender) |
| |
| Home street address |
| |
| Town |
| |
| Island |
| |
| Zip Code |
| |
| Mailing address (if different from home address) |
| |
| Email |
| |
| Phone number(s) |
| |
| Message may be left via email: [ ] No [ ] Yes<br>Message may be left via text message: [ ] No [ ] Yes<br>Message may be left via voicemail: [ ] No [ ] Yes |
| |
| Guardian: Name, Email, Phone (if applicable) |
| |

| |
|---|
| Emergency contact: Name, Relationship, Phone |
| |
| Primary care doctor: Name, Phone, Fax |
| |
| Therapist: Name, Phone, Fax |
| |
| Case manager/social worker: Name, Phone, Fax |
| |
| Name of Primary Insurance Company |
| |
| ID/Policy # |
| |
| Your relationship to the subscriber (ex. Self, Parent, Spouse) |
| |
| Subscriber’s Full Name, date of birth, and employer |
| |
| How did you hear about our services? |
| |
| Name of person completing this referral (or “self”) |
| |
| Please state in a few words your primary reason for seeking services/goals of care |
| |
| What type of clinician are you seeking? |
| [ ] Primary Care |
| [ ] Therapist/Counselor - mood, thoughts, behavior |
| [ ] Therapist/Counselor - substance use |
| [ ] Therapist/Counselor - relationship, family |
| [ ] Psychiatrist/Medication Management (If you wish to see a psychiatrist and do not have a primary care provider or a therapist, you must establish care with them before seeing a HI Utele psychiatrist. You may request these providers through HI Utele at the same time as a psychiatrist) |
| [ ] Medication Management - substance use |

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|---|
| |
| Prior Psychiatric Diagnoses (or “none”) |
| |
| Current Psychiatric/psychotropic/mental health medications (or “none”) |
| |
| Prior Psychiatric/psychotropic/mental health medications (or “none”) |
| |
| Medical Diagnoses (or “none”) |
| |
| Medications for physical health, herbs, vitamins, etc (or “none”) |
| |
| If you would like to have an interpreter for your sessions, please state preferred language (or “n/a”) |
| |
| Please check if you would like assistance with any of the following |
| [ ] access to a smartphone, tablet, or computer with webcam |
| [ ] connecting to the internet |
| |
| Days or times of the week you are unable to meet (or “none”) |
| |