

**PATIENT REGISTRATION FORM**

*Southlake Family Medicine,  
731 E. Southlake Blvd., Suite 100  
Southlake, TX 76092*

FOR OFFICE USE ONLY Acct # _____
-------------------------------------

Today's Date: \_\_\_\_\_

**Patient Information**

Full Name: Last	First	Middle	(Maiden)
Address: (Street or Box)		City	State Zip
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Email Address
Referred By:	Date of Birth	Age	Sex (circle one) Male Female
Occupation	Employer	Employer Address	
Marital Status (circle one) Single Married Widowed Divorced Separated	Spouse's Name		Race (circle one) American Indian Asian Black Hispanic White Other
If Student, Indicate School		If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):	
Emergency Contact (not living at same address)		Emergency Contact Phone # ( )	

**Responsible Party**

Guarantor Full Name: Last	First	Middle	(Maiden)
Address: (Street or Box)		City	State Zip
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Drivers License #
Date of Birth	Age	Sex (circle one) Male Female	Social Security # Patient Relationship to Guarantor
Employer	Employer Address		

**Insurance Information**

Name of <b>Primary</b> Insurance Company <b>1.</b>	Phone # ( )	Name of <b>Secondary</b> Insurance Company <b>2.</b>	Phone # ( )
Mailing Address		Mailing Address	
City	State Zip	City	State Zip
Policy Number	Group Number	Effective Dates of Policy From: To:	Policy Number Group Number Effective Dates of Policy From: To:
Policy Holder (if other than patient)	Date of Birth	Policy Holder (if other than patient)	Date of Birth
Social Security #	Relationship to Patient	Social Security #	Relationship to Patient
Policy Holder's Employer	Work Phone # ( )	Policy Holder's Employer	Work Phone # ( )
Employer Address		Employer Address	
City	State Zip	City	State Zip

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Southlake, TX 76092*

FOR OFFICE USE ONLY  
Acct # \_\_\_\_\_

Patient Name: \_\_\_\_\_

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:

I consent for \_\_\_\_\_ to authorize evaluation and treatment for my child named  
(Name(s): First & Last)

herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

Patient Name:		
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## Patient Preference Regarding Communication of Health Information

### I. Who to Contact

I hereby give permission to (*Southlake Family Medicine*) to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship
Name	Relationship
Name	Relationship

<input type="checkbox"/> I do not wish to disclose any information with anyone.
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### II. How to Contact

I wish to be contacted in the following manner:

#### PLEASE WRITE TELEPHONE NUMBERS BELOW

Home Telephone: #	Work Telephone: #	Cell Phone: #
<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/>	Written Communication <input type="checkbox"/> OK to mail to my home address _____ _____ _____
<input type="checkbox"/>	OK to mail to my work/office address _____ _____ _____
<input type="checkbox"/>	OK to fax to this number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

## HEALTH HISTORY

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete each question.

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DATE \_\_\_\_\_

**DRUG ALLERGIES** (please list specific reaction to each, especially if life-threatening)

\_\_\_\_\_

**MEDICATIONS** (list all including vitamins and supplements with doses and frequency of each – may attach list if desired)

\_\_\_\_\_

\_\_\_\_\_

**PHARMACY NAME & ADDRESS** \_\_\_\_\_

**MEDICAL PROBLEMS** (list every medical problem that you have including high cholesterol, diabetes, high blood pressure, abnormal pap smear, cancer, lung/heart/stomach/kidney/liver disease, & psychiatric disorders – **include year of onset for each**)

\_\_\_\_\_

\_\_\_\_\_

**PAST SURGERIES** (Ex: tonsils, appendix, gallbladder, cataracts, stents, breast biopsy, tubes tied, plastic surgery, prostate)

\_\_\_\_\_

**FAMILY HISTORY:**

**Living?      Age/Age at Death      Health Problems / Cause of Death**

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

Grandparents \_\_\_\_\_

Please list any illnesses that are prominent in other family members: \_\_\_\_\_

**SOCIAL HISTORY:**

**MARITAL STATUS** (circle one)    Single / Married / Partnered / Divorced / Separated

**OCCUPATION** \_\_\_\_\_ **EMPLOYER** \_\_\_\_\_

**NUMBER & AGES OF CHILDREN** \_\_\_\_\_

**TOBACCO USE** (circle one)    Current / Quit / Never                      If Current, Year Started \_\_\_\_\_

If Current: Cigarettes Y / N \_\_\_\_\_ packs/day    Cigars Y / N \_\_\_\_\_ cigars/week    Smokeless Y/N \_\_\_\_\_ cans/day

If Quit, Year Started \_\_\_\_\_ Year Quit \_\_\_\_\_    On average, how many packs per day did you smoke? \_\_\_\_\_

Does anyone in your home smoke? Y / N    Have you ever or do you currently use any illegal drugs? Y / N

Do you have any habits that make you at increased risk for HIV? Y / N                      Number of caffeinated drinks per day \_\_\_\_\_

**ALCOHOL USE** (circle one) Y / N    Type of alcohol \_\_\_\_\_                      Average number of drinks per day \_\_\_\_\_

**EXERCISE** – Do you exercise at all? Y / N    If yes, how many times per week? \_\_\_\_\_    Type \_\_\_\_\_

**SEATBELT USE** (circle one)    100%    75%    50%    25%    0%

**SUN EXPOSURE** (circle one)    FREQUENTLY OCCASIONALLY RARELY PAST    **SUNSCREEN** – Y / N

**PLEASE COMPLETE REVERSE SIDE OF QUESTIONNAIRE**

NAME \_\_\_\_\_

**HEALTH MAINTENANCE / PREVENTIVE CARE:**

	<b>MONTH/YEAR</b>	<b>RESULTS</b>
CHOLESTEROL PANEL	_____	_____
TB SKIN TEST	_____	_____
BREAST EXAM	_____	_____ Doctor _____
MAMMOGRAM	_____	_____
PAP SMEAR	_____	_____
BONE DENSITY TEST	_____	_____
DO YOU HAVE A GYNECOLOGIST FOR YEARLY EXAMS? IF SO, WHO?	_____	
STOOL CHECKED FOR BLOOD	_____	_____ (circle) Mail-In Cards / Rectal Exam
COLONOSCOPY	_____	Normal / Internal Hemorrhoids / Diverticulosis / Polyps Doctor _____ Next Colonoscopy Due in _____ Years
PSA (PROSTATE BLOOD TEST)	_____	_____
STRESS TEST	_____	Normal / Abnormal Type: Treadmill / Nuclear

**IMMUNIZATIONS:**

**MONTH/YEAR**

TETANUS BOOSTER	_____	Did shot include pertussis (Tdap)? Y / N / Unsure
FLU VACCINE	_____	
PNEUMONIA VACCINE	_____	
SHINGLES VACCINE	_____	
HPV VACCINE	_____	2 <sup>ND</sup> SHOT _____ 3 <sup>RD</sup> SHOT _____
HEPATITIS A VACCINE	_____	2 <sup>ND</sup> SHOT _____
HEPATITIS B VACCINE	_____	2 <sup>ND</sup> SHOT _____ 3 <sup>RD</sup> SHOT _____
HEPATITIS A/B COMBO	_____	2 <sup>ND</sup> SHOT _____ 3 <sup>RD</sup> SHOT _____
TB SKIN TEST	_____	

**DIABETIC EXAMS:**

**MONTH/YEAR RESULTS**

DILATED EYE EXAM	_____	_____ DOCTOR _____
HEMOGLOBIN A1C	_____	_____
URINE TEST FOR PROTEIN	_____	_____

Your answers will be documented confidentially into our electronic health record. We appreciate you answering each question as accurately as possible.



**PLEASE NOTE: THIS SIDE IS FOR RETURNING PATIENTS ONLY, NEW PATIENTS DO NOT HAVE TO COMPLETE.**

Do you currently smoke or use any tobacco products? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ On average, how many drinks per day? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How many times per week? \_\_\_\_\_ Type: \_\_\_\_\_

If you are a woman and get your well woman exams elsewhere, list date of last:

PAP SMEAR: \_\_\_\_\_ NORMAL / ABNORMAL

MAMMOGRAM: \_\_\_\_\_ NORMAL / ABNORMAL

**LIST MEDICATIONS & DOSAGES, INCLUDING VITAMINS/SUPPLEMENTS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_
13. \_\_\_\_\_
14. \_\_\_\_\_
15. \_\_\_\_\_

Have you had any surgeries in the past year that we are unaware of? \_\_\_\_\_

Do you have any new family history? \_\_\_\_\_

## HEALTHTEXAS PROVIDER NETWORK NOTICE OF HEALTH INFORMATION PRACTICES

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### **Understanding Your Health Record/ Information**

This notice describes the practices of HealthTexas Provider Network (HTPN) and that of its physicians<sup>1</sup> with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

#### **Your Health Information Rights**

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with

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<sup>1</sup> Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

your care and as provided by law. However, we are not required by law to agree to a requested restriction;

- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

#### **Our Responsibilities**

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at [www.baylorhealth.edu](http://www.baylorhealth.edu); and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

#### **Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

*We will use your health information for treatment.*

**For example:** We may disclose medical information about you to

doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

*We will use your health information for payment.*

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health care operations.*

**For example:** We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

*We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.*

**Business associates:** There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Organ procurement organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Communications for treatment and health care operations:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fundraising:** We may contact you as part of a fundraising effort.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Worker's compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse, neglect or domestic violence:** As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

**Judicial, administrative and law enforcement purposes:** Consistent with applicable law, we may disclose health information about you for judicial,

administrative and law enforcement purposes.

**Required or allowed by law:** We will disclose medical information about you when required or allowed to do so by federal, state or local law.

### **For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

**EFFECTIVE DATE: 02/01/06**

**VERSION: 2**

Patient Name: \_\_\_\_\_ Patient Identifier: \_\_\_\_\_



**ACKNOWLEDGMENT OF THE RECEIPT OF  
HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION  
PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians<sup>1</sup> may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

\_\_\_\_\_  
(Signature of Patient or Legal Representative)

\_\_\_\_\_  
(Date)

February 1, 2006  
(Effective Date of Notice)

<sup>1</sup>Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

Patient name \_\_\_\_\_

Medic # \_\_\_\_\_

## Electronic Communications to Patients

Baylor Office EHR is a joint effort of HealthTexas Physician Network physicians and other physicians aligned with Baylor Health Care System to fully support an electronic patient care experience through implementation of a common electronic health record platform. HealthTexas Physician Network (“HTPN”) is pleased to offer Baylor Office EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

### Use of Electronic Communication from HTPN to the Patient

Please check the appropriate box below:

Yes, I want HTPN to communicate my information with me through a secure system that is designed to keep **my** information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review:

**E-mail address:** \_\_\_\_\_

**(PLEASE PRINT CLEARLY AND DIFFERENTIATE NUMBERS FROM LETTERS)**

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

No, I do not want HTPN to use electronic communication as a way to communicate my information to me.

### HTPN E-mail Guidelines

- At this time, HTPN can only send e-mails *to* patients. **Currently, HTPN is not able to accept replies. However, e-mail can be sent through our website: [www.southlakefamilymedicine.com](http://www.southlakefamilymedicine.com).**
- All e-mail you receive from HTPN is sent under the name and e-mail account of DFW Centricity.
- You are responsible for notifying HTPN promptly of any changes to your e-mail address.
- All of HTPN’s electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the e-mail messages sent to you.

### Confidentiality and Privacy

- If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- HTPN will not share your e-mail address with anyone unauthorized to view your medical record.

### Consent and Agreement

*I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from HTPN. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

# Instructions for Receiving Secure Messages

1. You will receive an email in your Inbox from [BaylorofficeEHR@BaylorHealth.edu](mailto:BaylorofficeEHR@BaylorHealth.edu) or [name@BaylorHealth.edu](mailto:name@BaylorHealth.edu) (the name may be the physician or nurse). Note: please make sure you have your email set up to accept emails with the domain [BaylorHealth.edu](http://BaylorHealth.edu) so it will not be discarded as SPAM mail.
2. Open the email and **click** on the link in the message.

**BAYLOR Office EHR**

## Secure Message

You have received a secure message from Marek, Deirdre [DeirdreM@BaylorHealth.edu].

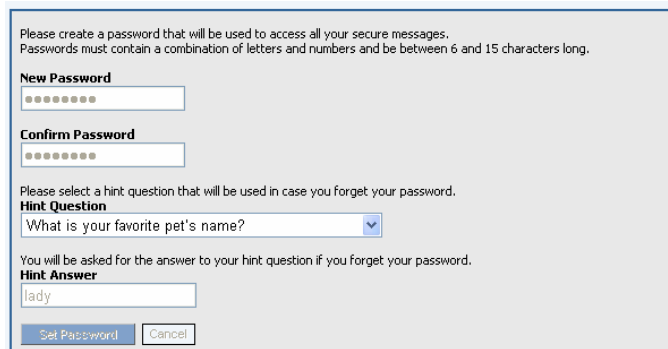
To retrieve this message click on the following link

[https://tst.baylorpatient.com/mc10/ViewMessage.aspx?key=4aad7wb8IESUQH\\_48Q5s75-G5GcnYw](https://tst.baylorpatient.com/mc10/ViewMessage.aspx?key=4aad7wb8IESUQH_48Q5s75-G5GcnYw)

3. A welcome greeting will appear that describes Secure Messaging. **Click** Next .



4. On the initial log-in, you will need to create a password. **It is important that you write down your password and put it in a secure location** because this same password will be used with any future messages received from your provider. **Type** in the information and **click** set password .



5. If you forget your password and attempt to enter the system, you will get locked out after three bad password attempts to enter your account. You will be locked out for 20 minutes before you can try again. Please make a note of your password and put it in a secure location. If you are still unable to get into the system, please contact [the referring physician office](#) for help.
6. You will be able to **view the secure message but will not have the option to reply**.



Name: \_\_\_\_\_  
Last First

DOB: \_\_\_\_\_  
mm/dd/yr



HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and primary language directly from patients or their caregivers. **The purpose of collecting this information is to ensure that all patients receive high-quality care.**

We would like for you to provide us with your race and ethnic background. We will only use this information to **review the treatment patients receive and make sure everyone gets the highest quality of care.**

First, do you consider yourself Hispanic/Latino? *Of the following choices, please choose the one that best describes your ethnicity.*

- Yes       No       Decline

Which category best describes your race? *Of the following choices, please choose the one that best describes your race. Race definitions can be found at the bottom of this page.*

- American Indian or Alaska Native       Native Hawaiian or Other Pacific Islander  
 Black or African American       Multiracial  
 White       Decline  
 Asian (includes Pakistan or Indian origins)

What language do you feel most comfortable speaking with your doctor or nurse? *Of the following choices please choose the one that best fits you.*

- English       Tagalog       Do not know  
 Spanish       Hindi       Decline  
 Vietnamese       Italian       Other (please provide): \_\_\_\_\_  
 Chinese       Korean       Sign Language or other Auxiliary Aid  
or Service

**Race Definitions:** **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Multiracial:** A person having more than one or a combination of the above origins