Kuhio Medical Center
REGISTRATION FORM

(Please print)

Today's date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First: MI:			Birth date:	Sex: M F	Marital status (circle one) Single / Mar / Div / Sep / Wid
Mailing address		Social Security no.:			Home phone no.:
Cell no.:	Employer:		Business phone:		Email:
Ethnicity: (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Race: (optional) ☐ American Indian or Alaskan native ☐ Asian ☐ African American ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other				Preferred Language: ☐ Chinese ☐ English ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Spanish ☐ Other:_____
Do you have an advanced directive or living will?		☐ Yes	☐ No		
Chose clinic because or referred to clinic by :		☐ Family/friend	☐ Insurance Plan		☐ Other:
Other family members seen here:					

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)						
Name of responsible party (Guarantor):						
Name of insurance:	Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Policy no.:	Group no.:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (living at same address):	Relationship to patient:	Home phone no.:	Work or cell no.:
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work or cell no.:
Whom may we talk to regarding your health?			
May we leave messages pertaining to your health on your home answering machine or cell phone voicemail?	Yes ☐ No ☐		

I authorize and consent to any diagnostic and/or medical treatment under the instruction of my attending physician. I understand that I will be expected to pay my portion for materials and services provided to me at the time of service. I authorize this office or its agent to release to my insurance company and designated utilization review and/or quality assurance organization any information necessary to expedite insurance payment. I understand that I am responsible for all charges regardless of insurance coverage.

Patient/guardian signature

Date