

Personal Information about you is needed so we can prepare required Federal & State reports and so we may contact you if necessary.

All information will be held confidential.

Patient Name: Last: _____ First: _____ M.I. _____

Mailing address: _____ City: _____ State: _____ Zip Code: _____

Residence address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (H) _____ (W) _____ (C) _____

Social Security #: ____/____/____ DOB: ____/____/____ Gender: [F] [M]

Insurance Information: (require copy of all insurance cards)

Primary Insurance Name: _____ ID#: _____

Patient's relationship to Insured: [] Self [] Spouse [] Child [] Other: _____

Insured Name: Last: _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: ____/____/____ DOB: ____/____/____ Gender: [F] [M]

Secondary Insurance Name: _____ ID#: _____

Patient's relationship to Insured: [] Self [] Spouse [] Child [] Other: _____

Insured Name: Last: _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: ____/____/____ DOB: ____/____/____ Gender: [F] [M]

Responsible Party Information:

Responsible Party Name: Last: _____ First: _____ M.I. _____

Relationship to Patient: [] Self (Skip to "Employer" if "Self") [] Spouse [] Parent [] Guardian

Residence address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: ____/____/____ DOB: ____/____/____ Gender: [F] [M]

*Employer: _____ Ph#: _____

Family Income: \$ _____ [] Monthly [] Annually Family Size: _____

Marital Status: [] Single w/o partner [] Single w/partner [] Married [] Divorced [] Separated [] Widowed
Homeless:

Agricultural Worker: [] No [] Unemployed Farm Worker [] Employed Farm Worker [] Seasonal [] Migrant [] Other

Homeless: [] Not homeless [] Homeless Shelter [] Transitional [] Street [] Doubling up
[] Public Housing Resident [] Other [] If Homeless: From: ____/____/____ to ____/____/____

Please provide additional Patient information

Most Prominent Ethnicity (Select One)

- [] Caucasian [] Japanese [] Tongan [] Hawaiian [] Filipino [] Chinese [] American Indian
[] Portuguese [] Hispanic [] Pacific Is. [] Korean [] Samoan [] Alaskan [] Marshallese
[] Other Asian [] African American

Primary Language:

- [] English [] Spanish [] Tagalog [] Ilocano [] Hawaiian [] Marshallese [] Japanese
[] Chinese [] Sign [] Other _____ Interpreter Needed: [] Yes [] No

U. S. Citizen:

- [] Yes [] No If No - Legal Resident: [] Yes [] No

Authorization and Release:

I authorize this office to release to the named insurance company any information necessary to secure insurance payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also hereby authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage.

Signature: _____ Date: _____

I give Hamakua Health Center permission to verify the financial and insurance information provided by me to determine eligibility for Hamakua Health Center services. I understand it is my responsibility to keep Hamakua Health Center informed of any changes in my family's income and insurance status. _____ (initials)

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, processing of insurance claims, and/or for qualification for services to which I may be eligible. _____ (initials)

I authorize and consent to diagnostic and/or medical treatment under the instruction of the attending physician for which my dependent, the authorized person(s) below, or I have sought care. _____ (initials)

Name: _____ Phone#: _____

Relationship: _____ DOB: _____

Name: _____ Phone#: _____

Relationship: _____ DOB: _____

Name: _____ Phone#: _____

Relationship: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

List a person we may contact in case of emergency

Name: _____ Relationship: _____ Phone: _____ DOB: _____

May we speak to this contact about your health? [] Yes [] No

May we say that it is Hamakua Health Center or Kohala Family Health Center when we contact you? [] Yes [] No

If "No", how can we reach you? _____

Signature (Patient/Responsible Party/Legal Guardian)

Date

Print name if other party than above is signing: _____

Witness: _____