Kuhio Medical Center
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: MI:	Birthdate:	Sex: M F	Marital status (circle one) Single / Mar / Div / Sep / Wid
Mailing address, ZIP CODE	Social Security no.:		Home phone #: ( )
Cell #: ( )	Employer:	Business phone: ( )	Email:

Ethnicity:	Race:	Preferred Language:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to report	☐ American Indian or Alaskan native ☐ Asian ☐ Black or African American ☐ More than one race ☐ Native Hawaiian or other pacific islander ☐ Refused to report ☐ White	☐ English ☐ Filipino ☐ Japanese ☐ Spanish ☐ Hawaiian ☐ Chinese ☐ Other:_____

Do you have an Advanced Directives or Living will?	❑ Yes	❑ No	
Chose clinic because/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):

Subscriber's name: INSURANCE:	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 #: ( )
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work or cell #: ( )
Whom may we talk to regarding your health?			
May staff 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*