PATIENT INFORMATION	Kihei-Wailea Medical Center	ADULT

Patient Information

Name	**Birthdate**		**Sex**
Social Security Number	**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other**		
Mailing Address	**City**	**State**	**Zip Code**
Physical Address	**City**	**State**	**Zip Code**
Primary Ph#	**May we leave messages from this office on this number?** ☐ **YES** ☐ **NO**		
Secondary Ph#	**Email**		
Employer	**Work Ph#**		

Emergency Contact Information

Name	**Birthdate**
Relationship To Patient	**Phone Number**
Employer	**Alternate Phone Number**
Ok to release medical, billing and/or appointment information to this person? ☐ **YES** ☐ **NO**	
Name	**Birthdate**
Relationship To Patient	**Phone Number**
Employer	**Alternate Phone Number**
Ok to release medical, billing and/or appointment information to this person? ☐ **YES** ☐ **NO**	
☐ *By initialing here, I decline to release medical information to anyone but myself. I decline to list emergency contacts.*	

Insurance Information

Primary	**Subscriber Number**
Subscriber Name	**Subscriber Birthdate**
Secondary	**Subscriber Number**
Subscriber Name	**Subscriber Birthdate**
Medicare Number	**Medicaid Number**

Release of Information

I understand and agree that this information sheet is up-to-date and will remain valid until I update it in writing.

I understand that by signing this form I am agreeing to release records to myself.

Patient Signature **Date**

Office Policies

Patient Name	**Birthdate**

You understand and agree to the terms of the following policies by initialing below.

_____ I received a copy and/or opportunity to review the Notice of Privacy Practices, Medication and Office policies.

_____ I understand that Kihei-Wailea Medical Center may choose with which insurances they participate.

_____ If Kihei-Wailea Medical Center cannot verify that the patient has active medical insurance and/or cannot confirm that the medical insurance will cover the services requested, I understand and agree that I am, as the guarantor, obligated to pay any or all charges at the time of service.

_____ I understand and agree that insurance verification is not a guarantee of payment. If Kihei-Wailea Medical Center submits any charges incurred at this facility to the patient's insurance company, and said insurance company does not pay, I am, as the guarantor, responsible for those charges.

_____ I understand and agree that Kihei-Wailea Medical Center will collect my estimated copayment/patient share at the time of service. Copayment/ patient share is subject to change at any time due to his/her insurance company.

_____ I understand and agree that if I, as the guarantor, cannot pay the patient's copayment/patient share at the time of service, I will be assessed a $5.00 surcharge.

_____ I understand and agree that if Kihei-Wailea Medical Center does not participate with the patient's insurance, I am, as the guarantor, obligated to place a deposit of $100 cash or a copy of a valid credit card for each patient before any services will be provided.

Patient Signature **Date**

Medical/Social History

Kihei-Wailea Medical Center

Today's Date

Patient Information

Name	**Date of birth**	**Sex**

Social Habits

Do you drink alcohol?	☐ NO ☐ YES	How often?	
Do you use tobacco/tobacco products?	☐ NO ☐ YES	How often?	
Do you have a history of substance abuse?	☐ NO ☐ YES		
Do you have a history of domestic violence?	☐ NO ☐ YES	N/A	
Would you like information on domestic violence?	☐ NO ☐ YES	N/A	
Do you exercise?	☐ NO ☐ YES	How often?	
Are you on a special diet?	☐ NO ☐ YES	Explain here:	

Allergies

List allergies to food, drugs, or other. If unknown, write none to my knowledge.

Medications

List medications and dosage you are presently taking.

Conditions

Check any conditions you presently have or have had in the past.

☐ Anemia	☐ Heart Disease	☐ Mental illness
☐ Arthritis	☐ Hepatitis	☐ Sexually transmitted diseases
☐ Asthma	☐ Headache	☐ Problems w/skin,hair,nails
☐ Birth defect	☐ HIV	☐ Stomach/digestive problems
☐ Cancer	☐ High blood pressure	☐ Stroke
☐ Depression	☐ High cholesterol	☐ Thyroid problems
☐ Diabetes	☐ Kidney problems	☐ Tuberculosis
☐ Epilepsy	☐ Liver problems	☐ Other _____
☐ Glaucoma		

Hospitalizations/Surgeries

List dates and descriptions.

Routine Checks

List date of last procedure. Ok to guess closest month and/or year.

Mammogram:

Colonoscopy:

Pelvic exam (Female Only):

Diabetic Eye Exam:

Family Medical History

List any known medical problems like stroke, heart disease, cancer or high blood pressure.

Father

Mother

Brother/Sister