ADULT FORM

KIHEI-WAILEA MEDICAL CENTER

221 PI'IKEA AVENUE, SUITE A, KIHEI HI 96753

PATIENTS NAME: LAST FIRST M.I. BIRTH DATE: GENDER:

SOCIAL SECURITY #: HOME PHONE #: CELL PHONE #: MARITAL STATUS:

MAILING ADDRESS: APT. # CITY STATE /PROVINCE ZIP CODE/POSTAL CODE

RESIDENCE ADDRESS: APT. # CITY STATE/PROVINCE ZIP CODE/POSTAL CODE

NAME OF EMPLOYER: OCCUPATION: BUSINESS PHONE #:

NAME OF SPOUSE: SPOUSE BIRTH DATE: SPOUSE SOCIAL SECURITY #:

EMERGENCY CONTACT: PHONE #: RELATIONSHIP TO PATIENT:

HOW DID YOU HEAR ABOUT US? NAME: ADDRESS:

KIHEI-WAILEA MEDICAL CENTER RESERVES THE RIGHT TO COLLECTA CREDIT CARD COPY AND/OR $100.00 CASH DEPOSIT FROM EACH PATIENT IF WE ARE UNABLE TO VERIFY INSURANCE ELIGIBILITY AT THE TIME OF SERVICE.

PATIENT SIGNATURE **TODAY'S DATE:**

X

VISITOR ONLY:

MAUI ADDRESS: HOTEL/CONDO RM. #: MAUI PHONE #:

REVISED 01/07/10