Patient Information	Kihei-Wailea Medical Center	ADULT
Name	**Date of birth**	**Sex**
Social Security Number	**Marital/Relationship Status**	
Mailing Address		
Physical Address		
Primary phone#	**Email**	
Secondary ph#	**Employer**	**Work ph#**

Emergency Contact/Spouse/Significant Other Information	
Name	**Date of birth**
Relationship to patient	**Phone number**
Employer	**Alternate phone number**
Ok to release medical, billing and/or appointment information to this person? YES NO	
Name	**Date of birth**
Relationship to patient	**Phone number**
Employer	**Alternate phone number**
Ok to release medical, billing and/or appointment information to this person? YES NO	

Insurance Information	
Primary	**Subscriber number**
Subscriber name	**Subscriber date of birth**
Secondary	**Subscriber number**
Subscriber name	**Subscriber date of birth**

Visitor Information	
Hotel/Condo Name	**Room/Apt #**

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

- I received a copy and/or an opportunity to review the Notice of Privacy Practices, Medication/Office policies.
- I understand that Kihei-Wailea Medical Center may choose with which insurances they participate.
- I understand that Kihei-Wailea Medical Center will attempt to verify eligibility for insurances with which they participate.
- If Kihei-Wailea Medical Center cannot verify 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/all charges at the time of service.
- I understand and agree that insurance verification is not a guarantee of payment, and if Kihei-Wailea Medical Center submits any charges incurred at this facility to the patient's insurance company, and his/her 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, and that the 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, for what ever reason, 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.
- I understand and agree that this information sheet is up-to-date and will remain valid until I update it in writing.

Patient Signature **Date**

Medical/Social History

Kihei-Wailea Medical Center

Patient Information

Today's Date_____

Name	**Date of birth**	**Sex**
Social Security Number	**Marital/Relationship Status**	
Primary phone number	**Secondary phone number**	**Work phone**
Employer	**Occupation**	

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

Hospitalizations/Surgeries

List dates and descriptions.

Family Medical History

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

Father _____

Mother _____

Brother/Sister _____