PATIENT INFORMATION	Kihei-Wailea Medical Center	ADULT

Patient Information

Name	**Birthdate**		**Sex**
Social Security Number	**Marital Status** Please circle **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?** Please circle **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? Please circle: **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? Please circle: **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

Patient Information

Today's Date_____

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
__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.

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