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#	Occupation	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 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