Patient Information	Kihei-Wailea Medical Center	PEDIATRIC
Name	**Date of Birth**	**Sex**
Address	**Apt#**	**Email**
City	**State**	**Zip**
Primary phone number	**Secondary phone number**	

Parent/Guardian/Emergency Contact Information	
Father's Name	**Date of birth**
Employer	**Phone number**
Mother's Name	**Date of birth**
Employer	**Phone number**
Guardian	**Date of birth**
Relationship to patient	**Phone number**
Employer	**Work phone number**

Other children in the household			
Name	**Date of birth**	**Name**	**Date of birth**
Name	**Date of birth**	**Name**	**Date of birth**

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#**

The patient's guarantor should read the following policies. You agree to the terms of these 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 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.

Parent/Guardian Signature	Date