

Patient Information		Kihei-Wailea Medical Center		PEDIATRIC	
<b>Name</b>		<b>Date of Birth</b>		<b>Sex</b>	
<b>Address</b>		<b>Apt#</b>	<b>Email</b>		
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Primary phone number</b>		<b>Secondary phone number</b>			
Parent/Guardian/Emergency Contact Information					
<b>Father's Name</b>			<b>Date of birth</b>		
<b>Employer</b>			<b>Phone number</b>		
<b>Mother's Name</b>			<b>Date of birth</b>		
<b>Employer</b>			<b>Phone number</b>		
<b>Guardian</b>			<b>Date of birth</b>		
<b>Relationship to patient</b>			<b>Phone number</b>		
<b>Employer</b>			<b>Work phone number</b>		
Other children in the household					
<b>Name</b>		<b>Date of birth</b>		<b>Name</b>	
<b>Date of birth</b>		<b>Name</b>		<b>Date of birth</b>	
<b>Name</b>		<b>Date of birth</b>		<b>Name</b>	
<b>Date of birth</b>		<b>Name</b>		<b>Date of birth</b>	
Insurance Information					
<b>Primary</b>			<b>Subscriber number</b>		
<b>Subscriber name</b>			<b>Subscriber date of birth</b>		
<b>Secondary</b>			<b>Subscriber number</b>		
<b>Subscriber name</b>			<b>Subscriber date of birth</b>		
Visitor Information					
<b>Hotel/Condo Name</b>				<b>Room/Apt#</b>	
The patient's guarantor should read the following policies. You agree to the terms of these policies by signing below.					
<ul style="list-style-type: none"> <li>• I received a copy and/or an opportunity to review the Notice of Privacy Practices, Medication/Office policies.</li> <li>• I understand that Kihei-Wailea Medical Center may choose with which insurances they participate.</li> <li>• I understand that Kihei-Wailea Medical Center will attempt to verify eligibility for insurances with which they participate.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• I understand and agree that this information sheet is up-to-date and will remain valid until I update it in writing.</li> </ul>					
<b>Parent/Guardian Signature</b>				<b>Date</b>	