PATIENT INFORMATION	Kihei-Wailea Medical Center	ADULT

Patient Information

Name	Birthdate	Sex
SSN #:	Marital Status (circle) Single / Married / Other	

Mailing Address	City	State	Zip
Physical Address	City	State	Zip

Phone Number OK to leave message on:

Email to use for online patient portal:

Emergency Contact Information / Release of Information

_____ *By initialing here, I decline to release medical information to anyone but myself.* ***I decline to list emergency contacts.***

Name	Birthdate
Relationship To Patient	Phone Number

OK to release medical, billing and/or appointment information to this person? (circle) **YES NO**

Name	Birthdate
Relationship To Patient	Phone Number

OK to release medical, billing and/or appointment information to this person? (circle) **YES NO**

Insurance Information

Primary	Subscriber ID #:
Subscriber Name	Subscriber Birthdate
Secondary	Subscriber ID #:
Subscriber Name	Subscriber Birthdate
Tertiary	Subscriber ID #:
Subscriber Name	Subscriber Birthdate
Medicare Number (MBI):	Medicaid ID #:

Patient Signature: **Date:**

Office Policies

Patient Name	**Birthdate**

I understand and agree to the terms of the following policies by initialing & signing below.

_____ I agree 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 agree to release records to myself.

_____ I received and/or opportunity to review the Notice of Privacy Practices, Medication/ Office policies.

_____ I understand that Kihei-Wailea Medical Center may choose which insurances they participate with.

_____ 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.

_____ If Kihei-Wailea Medical Center needs to reach the persons indicated on this current registration, any/ all contact information provided may be used to do so as deemed necessary.

_____ 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