Physician's Center Mililani
95-390 Kuahelani Avenue, #J1
Mililani, HI 96789

University Health Partners of Hawai`i

NEW PT REG _____

UPDATING _____

Date _____ Initial _____

677 Ala Moana Boulevard, Suite 1001 - Honolulu, Hi 96813-4100 - Phone: (808) 469-4900 - Fax: (808) 623-7872

(Please Print)

PATIENT REGISTRATION

Patient Last Name	First Name/Middle Initial	Date of Birth (Mo/Day/Yr)

Residence Address/Mailing Address	City	State	Zip

Social Security Number	Sex:	Marital Status:	Home Phone	Cell Phone
_ _ _-_ _-_ _ _ _	M F	Single Married Divorced Separated Widowed	Business Phone	Other Phone

Race:	Ethnicity:	Religion:	Language:

Name of Employer	Business Address

Employment Status:	Full Time Part Time Retired	**Student:**	Full Time Part Time

Primary Care Doctor (PCP)	Referring Doctor (if not referred by PCP)

Guarantor/Responsible Party for Bill

Name of Responsible Party (Guarantor)	Relationship to Patient	DOB	Phone Number

Residence Address/Mailing Address	City	State	Zip

Guarantor/Responsible Party Signature	Date	

Insurance Information

Primary Insurance	Subscriber's Name		Subscriber's DOB	Relationship to Patient
Subscriber Number	Coverage Code	Group Name	Employer/Branch of svs	
Secondary Insurance	Subscriber's Name		Subscriber's DOB	Relationship to Patient
Subscriber Number	Coverage Code	Group Name	Employer/Branch of svs	
Tertiary Insurance	Subscriber's Name		Subscriber's DOB	Relationship to Patient
Subscriber Number	Coverage Code	Group Name	Employer/Branch of svs	

Please complete the following if the patient is a *CHILD* under the age of 18

Father/Guardian's name	Relationship if not parent	Mother/Guardian's name	Relationship if not parent

Person(s) Who May Authorize Treatment for Child	Relationship to Patient

<u>All</u> Patients, Please complete the following in case of an emergency

Contact Person	Relationship to Patient	Home Phone/Business Phone/Cell

Patient, Parent/Guardian Signature	Date