University Health Partners of Hawai'i

WOMEN'S HEALTH SPECIALISTS
(808) 469-4982

(please print)

# PATIENT REGISTRATION

| | | | | |
|---|---|---|---|---|
| Primary Care Doctor (PCP) | | Referring Doctor (if not referred by PCP) | | |
| Patient Last Name | First Name/Middle Initial | | Date of Birth (Mo/Day/Yr) | |
| Residence Address/Mailing Address | | City | State | Zip |
| Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Sex:<br>M<br>F | Marital Status:<br>Single Divorced<br>Married<br>Separated Widowed | Home Phone<br>Business Phone/ Cell Phone | |
| Personal Email Address | | Name of Employer<br>Business Address | | |

**Guarantor/Responsible Party for bill (if other than patient)**

| | | | | |
|---|---|---|---|---|
| Name of Responsible Party (Guarantor) | Relationship to Patient | DOB | Phone Number | |
| Residence Address/Mailing Address | City | State | Zip | |

**Insurance Information**

| | | | |
|---|---|---|---|
| **Primary** Insurance | Subscriber Name | Subscriber DOB | Relationship to Patient |
| Subscriber Number | Coverage Code | Group Name | |
| **Secondary** Insurance | Subscriber Name | Subscriber DOB | Relationship to Patient |
| Subscriber Number | Coverage Code | Group Name | |

**If the Patient is a *Child* (under the age of 18), Please complete the following**

| | |
|---|---|
| Parent/Guardian Name | Relationship to Patient |
| Person(s) Who May Authorize Treatment for Child | Relationship to Patient |

**All Patients, Please complete the following in case of an emergency**

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

| | |
|---|---|
| **Patient, Parent/Guardian Signature (all information is true and correct to my knowledge)** | Date |

**The purpose of this section is for record-keeping and reporting requirements only. Periodic reports are made to the government on the following information. The data you provide will be kept confidential and used solely for statistical purposes. This section is voluntary, and has no impact on your care.**

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown/No Answer

Race: _____

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