University Health Partners of Hawai'i

FAMILY MEDICINE
(808) 627-3200

Pali Momi Outpatient Center
(Next to Pearlridge Center)
98-1005 Moanalua Road, Suite 3030
Aiea, HI 96701

NEW PT REG _____ **UPDATING** _____ **DATE** _____ **INITIAL** _____

(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

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	Date