Primary Care Clinic of Hawaii

PATIENT INFORMATION SHEET

Name:_____
First Name Middle Initial Last Name

Address:_____

_____

_____

Home Phone: (_____)_____ Sex: _____ Birthdate: _____

Mobile Phone: (_____)_____ Marital Status: ( ) Single ( ) Married Other ( )

Social Security No: _____ Referred By: _____

Employer: _____ Phone: (_____)_____

Address: _____

Job Title: _____

Emergency Contact: _____ Phone: (____)_____

Relationship:_____ Occupation:_____

Employer: _____ Phone: (____)_____

Responsible Party: _____ Phone: (____)_____

Address:_____

Primary Insurance: _____ Policy No: _____

Subscriber: _____ Relationship _____ Birth date: _____

Other Insurance: _____ Policy No: _____

Subscriber: _____ Relationship _____ Birth date: _____

Insurance Authorization - Please Read and Sign

I hereby authorize my doctor to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible not covered by insurance.

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care financing administration and its agents any information needed to determine these benefirst or the benefits payable for related service.

Signature: _____ Date: _____