KOHALA COAST URGENT CARE

62-100 KAUNAOA DRIVE, KAMUELA, HI 96743
PH: (808) 880-3221 FAX: (808) 475-0061

Patient Registration Form

Date: _____ Reason for Visit: _____

Name: First: _____ MI:_____ Last:_____

Date of Birth: _____ **Gender**: Male Female **SSN**:_____

Marital Status: Single Married Divorced Widowed Legally Separated

Primary Language: _____ What is your race:_____

Home Mailing Address: _____ **Apt #**:_____

City: _____ **State**: _____ **Zip**:_____

Current address is different from above (ex. hotel) _____

Cell Phone: _____ Ok to send appointment reminders to your cell phone: YES [ ] NO [ ]

Email Address: _____ Ok to send appointment reminders to your email: YES [ ] NO [ ]

Occupation: _____ **Employer**: _____

Primary Care Provider (PCP): _____ **PCP Location**: _____

****INSURANCE INFORMATION**** [***PLEASE PROVIDE YOUR INSURANCE CARDS***]

Primary Carrier: _____ Policy #: _____

Subscriber: _____ Relation to patient: _____

Secondary Carrier: _____ Policy #: _____

Subscriber: _____ Relation to patient: _____

Preferred Pharmacy: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

CURRENT MEDICATIONS / SUPPLEMENTS YOU ARE TAKING			
Name of Medication/Supplement	**Dosage / Strength**	**Directions**	**Prescribed by**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Patient Name: _____ Date of Birth: _____

10.			

PAST SURGICAL HISTORY

HAVE YOU EVER HAD SURGERY? YES NO If YES, please list the surgeries and month/year done.

PLEASE LIST ALL KNOWN ALLERGIES TO FOOD OR MEDICATION:

YOUR MEDICAL HISTORY, HAVE YOU EVER HAD:

Asthma	Yes / No	Depression	Yes / No	Stroke	Yes / No
AIDS or HIV+	Yes / No	Chronic Lung Disease	Yes / No	Limb Circulation Problems	Yes / No
Hepatitis	Yes / No	Epilepsy / Seizures	Yes / No	Kidney Problems	Yes / No
Diabetes	Yes / No	Cancer	Yes / No	Thyroid Problems	Yes / No
High Blood Pressure	Yes / No	Tuberculosis	Yes / No	Acid Reflux	Yes / No
Heart Disease	Yes / No	Shingles	Yes / No	High Cholesterol	Yes / No
Back Pain	Yes / No	Neck Pain	Yes / No	Knee Pain – Left / Right	Yes / No
Gout	Yes / No	Foot Pain – Left / Right	Yes / No	Shoulder Pain – Left / Right	Yes / No

Others not listed:

FAMILY HISTORY

Problem		**If YES, who?**	**Problem**		**If YES, who?**
Neck Pain	Yes / No		High Blood Pressure	Yes / No	
Cancer: Type:	Yes / No		Heart Disease	Yes / No	
Diabetes	Yes / No		Stroke	Yes / No	
Epilepsy / Seizures	Yes / No		Back Pain	Yes / No	

Others not listed:

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the member(s) allowed with a contact phone number:

Signature: _____ **Date:** _____

The Notice of Privacy Practices is posted in the waiting area and can be found at kohalacoasturgentcare.com.
I consent to the use or disclosure of my protected health information (PHI) by Kohala Coast Urgent Care, LLC for the purpose of treatment, payment, and health care operations.

Signature: _____ **Date:** _____

The Patient Rights and Responsibilities is posted in the waiting area and can be found at kohalacoasturgentcare.com.
I understand and agree to comply with the terms and conditions:

Signature: _____ **Date:** _____