4510 Salt Lake Blvd #B3 Honolulu, HI 96818

PATIENT REGISTRATION

First Name:________________ Last Name:________________ Middle Initial:________

Preferred Name:________________________________

Social Security #:________________ Birth date:________________ Sex: ○ Female ○ Male

Address:________________________ City / State / Zip:________________

Employer:________________________ Occupation:________________

Cell Phone:____________ Home Phone:____________ Work Phone:____________

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

E-mail:________________________ ☐ I would like to receive email correspondences

Emergency Contact Information

1) Full Name:________________ Relationship:____________ Phone:____________

2) Full Name:________________ Relationship:____________ Phone:____________

Responsible Party: (if someone other than the patient)

First Name:________________ Last Name:________________ Middle Initial:________

Address:________________________________

City / State / Zip:________________________________

Cell Phone:____________ Home Phone:____________ Work Phone:____________

Primary Insurance Information: Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Name of Subscriber:________________ Subscriber Date of Birth:________________

Insurance Company:________________ Subscriber ID: ________________

Employer:________________________________

Address:________________________ City / State / Zip:________________

Secondary Insurance Information: Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Name of Subscriber:________________ Subscriber Date of Birth:________________

Insurance Company:________________ Subscriber ID: ________________

Employer:________________________________

Address:________________________ City / State / Zip:________________