

KA WAI OLA FAMILY MEDICAL CLINIC
REGISTRATION FORM

Patient Registration Form Date: _____

PATIENT INFORMATION:

Name: _____ Age: _____ Sex: M F Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Home phone: _____ Cell Phone: _____ Home Phone: _____

Email: _____ Social Security #: _____

Ethnicity/race: _____

Last primary care physician: _____ Office Phone: _____

How did you hear of our clinic? _____

PARENT/GUARDIAN (if applicable):

Name: _____ Relationship: _____ Date of Birth: _____

Address _____ City/State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Social Security #: _____

Employer: _____ Occupation: _____

Work Address: _____ City/State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

PRIMARY

Insured Name: _____

Insured Date Of Birth: _____

Insured Employer: _____

ID: _____

Social Security #: _____

Group#: _____

Your Relationship To Insured: _____

SECONDARY

Insured Name: _____

Insured Date Of Birth: _____

Insured Employer: _____

ID#: _____

Social Security #: _____

Group#: _____

Your Relationship To Insured: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Signature: _____

Date: _____