

HAWAII FAMILY PHYSICIANS

(PLEASE PRINT)			PATIENT INFORMATION			
Patient's Last Name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Permanent street address:		Is this your mailing address? Y <input type="checkbox"/> or N <input type="checkbox"/>		Social Security number:		Home phone number: ()
P.O. Box:		City:		State/ Zip code:		Cell phone number: ()
My Occupation: Retired? Y / N		My Employer:		My Employer's phone number: ()		
I chose this office because/referred to by (Please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other (explain) ☺		
Other family members seen here are:						
If patient is a minor, list name of parent or legal guardian:					Cell & home phone numbers: ()	
If YWAM staff/student, list Immunizations needed:				List all allergies :		
If YWAM staff /student: You must list immediate family member's name, address, phone # - (who does not live with you) for any forwarding info:						
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) & ID TO THE RECEPTIONIST)						
Are you (the patient) covered by insurance? (check one) YES <input type="checkbox"/> NO INSURANCE – self pay <input type="checkbox"/>						
Person responsible for bill:		Birth date:		Address (if different):		Home phone number: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:		Employer address:		Employer phone number: ()
Primary Insurance:				Subscriber's ID or Member Number:		
The PCP listed on insurance card is:		Effective date is		Do you have Quest? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other
Subscriber's name:		Subscriber's S.S. number:		Subs' Birth date:		Group number: Policy number: Co-payment: \$
Secondary insurance (if applicable):				Subscriber's name:		Group number: Policy number:
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other
IN CASE OF EMERGENCY						
Name of friend or relative (Someone NOT living at your address):			Relationship to patient: Cell # ()		Home phone #: () Work phone #: ()	
<p>I certify that the above information is true to the best of my knowledge. Furthermore, I understand that <i>I am authorizing the following:</i></p> <ol style="list-style-type: none"> 1. The release of any medical information by Hawaii Family Physicians and my insurance companies required to process claims regarding the above patient as might be necessary and that this may include information relative to substance abuse, HIV status, STDs (sexually transmitted diseases), and/or mental conditions. The release of any necessary medical information to specialists that my provider refers me to. 2. Payment of all basic major medical insurance, Medicare and /or Medicaid benefits will be made directly to Hosanna LLC, Hawaii Family Physicians, for all medical services rendered to above patient. I will pay my co-pay and/or deductible <i>at the time of service</i> OR <i>payment in full</i> if no insurance. 3. The administration of medical treatment by Dr. David Arthurs, Dr. Beth Catanzaro, or any nurse practitioner working for Hawaii Family Physicians. 4. I agree that I'm financially responsible for any balance & will give 24 hours notice for cancellation or changes to all appointments or pay a \$50 fee. 						
Patient / Guardian signature:					Date:	