WAIMĀNALO HEALTH CENTER

Patient Registration: COMMUNITY OUTREACH

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

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

Legal Sex (Please check one)* ☐ Male ☐ Female

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Mailing Address	City	State	Zip Code

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address
( ) -	( ) -	( ) -	

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (pick one below that best describes you):

☐ African American/Black ☐ Caucasian ☐ Chinese ☐ Chuukese ☐ Filipino ☐ Guamanian
☐ Japanese ☐ Korean ☐ Laotian ☐ Marshallese ☐ Micronesian ☐ Native American
☐ Native Hawaiian ☐ Portuguese ☐ Puerto Rican ☐ Samoan ☐ Tongan ☐ Vietnamese
☐ Other Asian ☐ Other Pacific Islander ☐ All Other (please specify): _____

PARENT OR LEGAL GUARDIAN INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address
( ) -	( ) -	( ) -	

_____ Initials

I agree that all charges that are not directly paid by my insurance company or the City & County of Honolulu will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or City & County of Honolulu in order to process claims on my behalf. I authorize payment of medical benefits to WHC for services rendered.

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

I authorize WHC to call my residence and/or cellular phone for an appointment reminder. If I am not available, I also authorize WHC to communicate the reminder by leaving a message which will identify the call coming from WHC and will include the date and time of my appointment.

_____ Initials

I received the Privacy Practice Notice.

_____ _____
Patient Signature Date Signed

_____ _____
Signature of Parent/Legal Guardian Date Signed

FOR OFFICE USE ONLY

MEDICAL SERVICES – Record #_____

Pt Status Type:	**Valid ID:**	**Insurance:**
☐ Scheduled ☐ Inactive ☐ Non-WHC Active ☐ Dental Patient Only	☐ Scan ID ☐ Update NG Pt Picture	☐ Scan Card ☐ Update Info/Card

Collected By: _____ Date: _____ Entered By: _____ Date: _____