Patient Registration

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname

SSN Required for VA, Tricare &Medicare	Date of Birth	Gender ❒Male ❒Female	Marital Status ❒Single ❒Married ❒Divorced ❒Separated ❒Widowed ❒Life partner

Race/Ethnicity
❒Asian ❒White ❒Native Hawaiian/Other Pacific Islander
❒African American ❒American Indian or Alaskan Native ❒Hispanic/Latin

Employment Status ❒Full-time ❒Part-time ❒Retired ❒Self-employed ❒Student	Employer

Street Address	Please provide primary and secondary phone numbers so we can contact you and leave messages to include appointment reminders and test results. Please put a CHECKMARK by your PRIMARY number	
City	Cell phone number ❒	Home phone number ❒
State / Zip code	Email	

PO Box	PO Box Zip Code	Would you like to be enrolled in the Patient Portal ❒Yes ❒No (cell phone and email required)

Primary Care Provider	Referring Physician

PHARMACY INFORMATION

Preferred Pharmacy	Secondary Pharmacy
Location/Address	Location/Address
Phone number	Phone Number

PRIMARY INSURANCE HOLDER/PERSON RESPONSIBLE FOR BILL ❒ SELF

LAST NAME	FIRST NAME	MIDDLE INITIAL	Date of Birth
Patient Street Address		Cell phone number	Home phone number

City	State	Zip code	Relationship to patient ❒Child ❒Spouse ❒Parent ❒ Other

Employer Name	Employer Street Address

EMERGENCY CONTACT

Last name	First name		Middle initial	
Street Address			Cell phone number	Home phone number
City	State	Zip code	Relationship to patient ❒Child ❒Spouse ❒Parent ❒ Other ______________	

INSURANCE INFORMATION

Name of PRIMARY INSURANCE:		**Name of SECONDARY INSURANCE:**	
Member /Policy Holder if different from patient (Last, First, MI)		Member /Policy Holder if different from patient (Last, First, MI)	
Member/Policy Holder ID #	Date of Birth	**Member/Policy Holder ID #**	Date of Birth
Group #	Insurance company Phone number	**Group #**	Insurance company Phone number
Insurance Company Address		Insurance Company Address	
City	State Zip Code	City	State Zip Code

AUTHORIZATION, ASSIGMENT OR BENEFITS, AND REFERRING MEDICAL RELEASE

I hereby authorize the release of medical information, including complete medical records, test results, and billing information to my insurance company, and to the other medical professionals and medical care institutions, that I may be referred to for treatment.

I understand this information will be used to review investigate, or make payment of a claim, and review records for quality improvement initiative, audit compliance, utilization management, and complaint resolution.

I authorize direct payment to Hawaii Heart Associates for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services.

I agree to pay legal interest, collection expenses and attorneys' fees incurred to collect the amount I may owe.

I understand that in Hawaii, a general excise tax applies to medical services provided by group and private practice physicians, and I will be responsible for paying this fee.

A photocopy of this authorization shall be considered as effective and valid as the original.

Printed Name: ____________________________Signed: _____________________ Date: ____________________