Primary Care Partners of Hawaii, LLC

Patient Information

Name:_____ Gender: M or F. Date_____

Mailing Address:_____ SSN:_____ D.O.B.:_____

City/State/Zip:_____Marital Status: S M W D Phone:_____

Home Address:_____ Cell:_____

City/State/Zip:_____ Work:_____

Email Address:_____

Patient Employment Information

Employer Name:_____ Department_____

Employer Address:_____ Supervisor Name _____

City/State/Zip:_____Work Phone _____

Insurance

Primary Insurance:_____Subscriber:_____Subscriber's DOB:_____

Member #:_____ Relationship to Subscriber:_____

Secondary Insurance:_____ _____Subscriber:_____ Subscriber's DOB:_____

Member #:_____ Relationship to Subscriber:_____

Emergency Contact:

1st Name:_____ Home Ph.:_____ Cell Ph.:_____

Address:_____Relationship:_____

2nd Name:_____ Home Ph.:_____ Cell Ph.:_____

Address:_____Relationship:_____

Please list the names of those whom we may disclose your Medical Information

For example: Spouse, Parent, Children, etc. _____,_____

_____,_____,_____

Will you allow our office staff to leave medical related messages on your answering machine? Y or N

Will you allow our staff to leave appointment reminders on your answering machine? Y or N

Authorize for Treatment , Release of Information & Assignment of Benefits

I hear by authorize and consent Primary Care Partners of Hawaii, LLC and/or its representative to provide diagnostic and/or medical treatment to me and also authorize the release of any medical and pertinent information for the purpose of processing my health insurance claim(s). I authorize direct payment by my health insurance to Primary care Partners of Hawaii, LLC and understand that I am responsible for all payment of services to include deductibles, co-payments, and/ or non-covered benefits. I understand and agree that I am responsible for any balance for professional services rendered, regardless of my insurance status. I verify that the information provided above is correct and will notify you of any changes to the above information. I have also received/ reviewed HIPAA Privacy Rule.

Signature:_____ Date:_____

Relationship (if patient is a minor or requires guardianship):_____