University Health Partners of Hawai'i

(please print)

PATIENT REGISTRATION

Primary Care Doctor (PCP)		Referring Doctor (if not referred by PCP)		
Patient Last Name	First Name/Middle Initial		Date of Birth (Mo/Day/Yr)	
Residence Address/Mailing Address		City	State	Zip
Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Sex: M F	Marital Status: Single Divorced Married Seperated Widowed	Home Phone Business Phone/ Cell Phone	
Personal Email Address		Name of Employer Business Address		

Guarantor/Responsible Party for bill (if other than patient)

Name of Responsible Party (Guarantor)	Relationship to Patient	DOB	Phone Number	
Residence Address/Mailing Address	City	State	Zip	

Insurance Information

Primary Insurance	Subscriber's Name	Subscriber's DOB	Relationship to Patient
Subscriber Number	Coverage Code	Group Name	
Secondary Insurance	Subscriber's Name	Subscriber's DOB	Relationship to Patient
Subscriber Number	Coverage Code	Group Name	

If the Patient is a *Child* (under the age of 18), Please complete the following

Parent/Guardian's Name	Relationship to Patient
Person(s) Who May Authorize Treatment for Child	Relationship to Patient

All Patients, Please complete the following in case of an emergency

Contact Person	Relationship to Patient	Home Phone/Business Phone/Cell

Patient, Parent/Guardian Signature (all information is true and correct to my knowledge)	Date

The purpose of this section is for record-keeping and reporting requirements only. Periodic reports are made to the government on the following information. The data you provide will be kept confidential and used solely for statistical purposes. This section is voluntary, and has no impact on your care.

Ethnicity: ___ Hispanic of Latino ____ Non Hispanic or Latino ____ Unknown/No Answer

Race: _____