WAIKIKI HEALTH
MEDICAL & DENTAL · BEHAVIORAL HEALTH · SOCIAL SERVICES

PATIENT REGISTRATION FORM

PLEASE COMPLETE AND PRINT THE FORM PRIOR TO COMING FOR YOUR APPOINTMENT.

PATIENT INFORMATION

First Name: _____ M.I.: _____ Legal Last Name: _____ Suffix: _____

Preferred Name: _____ Date of Birth: _____

Address: _____ Legal Sex*: _____

City: _____ State: _____ Zip: _____

*The sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best number to use (check all that apply): ☐ Home ☐ Cell ☐ Work OK to leave voicemail? ☐ Home ☐ Cell ☐ Work

May we text you appointment reminders? ☐ Yes ☐ No Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

DEMOGRAPHICS

This demographic information may be used for funding purposes and to improve patient care.

Preferred Language: ☐ English ☐ Other _____ Do you need an interpreter ☐ Yes ☐ No

Ethnicity: ☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Spanish Origin
☐ Chicano/a ☐ Latino/a ☐ Other Hispanic ☐ Non-Hispanic

Race: ☐ Caucasian ☐ African American ☐ Filipino ☐ Chinese ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Native American ☐ Native Alaskan ☐ Asian Indian ☐ North African
☐ Middle Eastern ☐ Native Hawaiian ☐ Yapese ☐ Chuukese ☐ Fijian ☐ I-Kiribati
☐ Kosraen ☐ Marshallese ☐ Tongan ☐ Pohnpeian ☐ Samoan ☐ Tahitian
☐ Tokelauan ☐ Palauan/Belauan ☐ Chamorro/Chamoru ☐ Other: _____

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

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay ☐ Bisexual ☐ Don't Know
☐ Choose not to disclose ☐ Something else, please describe: _____

Gender Identity: ☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female ☐ Gender Non-Conforming ☐ Choose not to disclose
☐ Additional gender category/Other, please specify: _____

Assigned Sex at Birth: ☐ Male ☐ Female

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

INCOME

Family Income: $ _____ ☐ Monthly ☐ Yearly | Family Size*: _____ *Include yourself, spouse, and children under the age of 18.

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ADDITIONAL INFORMATION

Occupation: _____

Employer: _____ Employer Phone #: _____

Citizenship: ☐ U.S. Citizen ☐ Naturalized Citizen ☐ Permanent Resident ☐ COFA Migrant ☐ Student Visa ☐ Immigrant

Education: ☐ College (degree: _____) ☐ High School ☐ 9th-12th Grade ☐ 8th Grade and below

Agricultural Worker: ☐ Yes (If yes, ☐ seasonal or ☐ migrant) ☐ No ☐ Decline to answer

Homelessness: ☐ Yes ☐ No

If homeless, where are you living: ☐ Shelter ☐ Car ☐ Double Up ☐ Transitional ☐ Street Other _____

School-based Health Center Patient: ☐ Yes ☐ No ☐ Decline to answer

Public Housing Patient: ☐ Yes ☐ No ☐ Decline to answer

Veteran: ☐ Yes ☐ No

INSURANCE INFORMATION – *Please present your insurance card(s) to the receptionist.*

Insurance #ID: _____ Secondary Insurance #ID: _____

Insured Name (if different from patient): _____ Phone: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Responsible Party – If different from patient, please complete for the individual responsible for payment.

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

RELEASE OF INFORMATION

I understand that Waikiki Health may use or disclose my health information, to the minimum extent necessary, for the purpose of obtaining payment from my insurers and other payors, for other qualified health care operations, and within the limits of the law. My health information may include, but is not limited to the following:

- HIV/AIDS
- Drug/Alcohol Use
- Sexually Transmitted Infections (STI)
- Appointments
- Psychiatric Disorders/Mental Health
- Treatment for my care

I understand that this information will only be released for the purpose of obtaining payment from my insurers and other payors, for other qualified health care operations, and within the limits of the law. I consent to the release of this information for these purposes only.

Signature (Patient/Responsible Party/Legal Guardian): _____ Date: _____

Print Name: _____

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HOW DID YOU HEAR ABOUT US?

☐ Advertising ☐ Primary care physician ☐ Specialist physician ☐ Friend ☐ Word of mouth

☐ Patient ☐ Hospital ☐ Insurance company ☐ Other: _____

PRIVACY

Notices on File: ☐ Privacy Notice, Release of Billing Information and Assignment of Benefits

Consent to Call: ☐ Yes ☐ No (Patient agrees to receive automated phone calls on their mobile phone. Depending on the features your practice offers, phone calls may be about appointments, test results, and more.)

CONSENT TO TREATMENT

I understand that Waikiki Health is an integrated clinic with both medical and behavioral health services. **I authorize and consent to any diagnostic and/or medical and/or behavioral health treatment under the instructions of the attending provider for which my dependent or I have sought care.**

Signature (Patient/Responsible Party/Legal Guardian): _____ Date: _____

Print Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Waikiki Health keeps a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. Waikiki Health will not disclose your record to others unless you direct us to do so or unless the law authorizes or requires us to do so. You may see your record or get more information about it by contacting the Privacy Officer at (808) 922-4787. Waikiki Health's *Notice of Privacy Practices* describes in detail how your health information may be used and disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Waikiki Health's Notice of Privacy Practices:

Signature (Patient/Responsible Party/Legal Guardian): _____ Date: _____

I certify that everything on this form is true and complete. I understand that falsification may result in the disqualification of services at Waikiki Health for me and my family. I grant Waikiki Health permission to verify this information with income sources listed above.

Signature (Patient/Responsible Party/Legal Guardian): _____ Date: _____

ASSIGNMENT OF BENEFITS

PLEASE NOTE, WITHOUT YOUR PERMISSION TO BILL YOUR PRIVATE, STATE, OR GOVERNMENT INSURANCE, YOU ARE OBLIGATED TO PAY FOR ALL COSTS FOR SERVICES PRIOR TO THEM BEING RENDERED.

I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to permit the Waikiki Health to bill my insurance. Once health care information is disclosed, the person or organization that receives it may redisclose it. I may revoke this authorization in writing. If I did, it would not affect any disclosures already made by Waikiki Health resulting from this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. To revoke this authorization, I can write a letter to Waikiki Health; ATTN: Compliance Officer, 277 Ohua Avenue, Honolulu, HI 96815. Waikiki Health reserves the right to modify the Notice of Privacy Practices. The current version is available at www.waikikihealth.org or through the reception staff. You have the right to view the full version of this policy prior to signing this consent.

Signature (Patient/Responsible Party/Legal Guardian): _____ Date: _____

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