KAPOLEI FAMILY MEDICAL CENTER
590 FARRINGTON HWY, 526A
KAPOLEI, HI 96707
PH: (80) 674-2930 FAX: (808) 674-2950

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

PATIENT NAME: _____ **DOB:** _____
LAST NAME FIRST NAME M.I.

SSN: _____ **SEX:** _____ **Race:** _____ **Ethnicity:** Non-Hispanic Hispanic

HOME ADDRESS: _____

Cell#: _____ **Work#:** _____ **Home#:** _____

Email: _____ **MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOW PARTNER

EMPLOYMENT INFORMATION:

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYMENT STATUS: Full-Time Part-Time **RETIRED:** NO YES: _____
START DATE

RESPONSIBLE PARTY INFORMATION (IF UNDER 18 YEARS OF AGE):

GUARANTOR NAME: _____ **DOB:** _____

MAILING ADDRESS: _____

CONTACT NUMBER: _____

EMERGENCY CONTACT:

NAME: _____ **RELATIONSHIP:** _____

CONTACT #: _____

INSURANCE INFORMATION (IF YOU ARE NOT THE SUBSCRIBER):

INSURANCE CARRIER: _____ **SUBSCRIBER ID/MEMBER #:** _____

NAME OF SUBSCRIBER: _____ **DOB:** _____

CONTACT #: _____ **RELATIONSHIP:** _____

EMPLOYER: _____ **OCCUPATION:** _____