Ali'i Health Center

Patient Registration Form

PATIENT INFORMATION:

First Name: __________________________ Middle Initial: ____ Last Name: ____________________________

Date of Birth: ______________Social Security Number___________________ Gender: ____Male ____Female

Mailing Address: ________________________________City: ______________ State: _____Zip:____________

Physical Address (Required for Prescriptions): ____

City: ________________________________ State: _____________________ Zip: ________________________

Home Phone: ___________________ Work Phone: ___________________ Cell: _________________________

Email: ____________________________________ Dominant Hand (Please circle): Right Left

Marital Status:	Race:	Ethnicity:	Primary Language:
Single___ Married___	Native Hawaiian___ Other Pac. Islander___	Latino/Hispanic___	English___
Divorced___ Widowed___	Asian___ Black/African American___	Not Hispanic___	Spanish___
Legally Separated___	White/Caucasian___ Native American Indian/	Decline to Specify___	Other________________
Decline to Specify___	Alaskan Native___ More than one race___		_
	Other_____________ Decline to Specify___		

WHO IS YOUR PRIMARY CARE PROVIDER? (MUST BE PROVIDED BELOW)

NAME:

EMPLOYER

NAME: **PHONE#:** **FAX#:**

PERSON(S) RESPONSIBLE FOR PAYMENT (GUARANTOR):

First Name: __________________________ Middle Initial: ____ Last Name: _____________________________

Date of Birth: ________________ Relationship to patient: ___Self ___Spouse ___Parent/Guardian ___Other

Address: ____City: _______________________________

State: ____________________________ Zip: __________________ Phone #: _____________________________

INSURANCE INFORMATION (NEED COPY OF ALL INSURANCE CARDS):

Primary Insurance Co. _______________________________ Identification #: __________________________

Patient's relationship to person having insurance: _____Self ____Spouse ____Child ____Other

Subscriber or Member: ____

First Name: __________________________ Middle Initial: ____ Last Name: _____________________________

Date of Birth: ________________ Gender: ____Male ____Female

Address: ____

City: ____________________________________State: ____________________Zip:_______________________

Secondary Insurance Co. _______________________________ Identification #: _________________________

Subscriber or Member: ____

First Name: __________________________ Middle Initial: ____ Last Name: _____________________________

Date of Birth: ________________ Gender: ____Male ____Female

Address: ____

City: ____________________________________State: ____________________Zip:_______________________

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ALTERNATE CONTACT INFORMATION:

Emergency Contact

Name: ____ Relationship: ________________________________

Phone: _______________________________ May we speak to this person about your health? ____Yes ____No

May we speak to anyone else about your health? __Yes __No *(Please list below)*

Name: ______________________Relationship: _______________________Phone: _____________________

Name: ______________________Relationship: _______________________Phone: _____________________

PREFERRED PHARMACY (MUST BE PROVIDED BELOW):

NAME:	LOCATION:

NO SHOW/SCHEDULING POLICY:

I acknowledge that reminder calls and/or text messages are a courtesy. Patients are ultimately responsible for their appointment time. No show and cancellations less than 24 hours may result in a charge of $25.00 _______ ***(Initial here).***

I acknowledge that **repeat no-shows and cancellations** may result in termination from the practice. I acknowledge that Ali‘i Health Center’s specialty providers are on-call at the hospital for emergencies. I understand there may be occasions when they are called away from the clinic for an emergency, which may delay your appointment, or cause it to be rescheduled. ***(Initial here):*** ______

PAYMENT AT TIME OF SERVICE:

I acknowledge that all co-payments or deductibles required by a primary insurance policy must be paid at the time of service. Patients without insurance coverage are required to pay at the time of service, and/or make arrangements with the billing department. All past due balances are required at time of service. _______ ***(Initial here)***

I will be charged a fee of $25.00 each check returned by my bank for non-sufficient funds ***(Initial here):***______

PRESCRIPTION MEDICATION GUIDELINES

I acknowledge the following:

1. **ALI`I HEALTH CENTER DOES NOT OFFER CHRONIC PAIN MANAGEMENT OR CHRONIC PSYCHIATRY MANAGEMENT AND WILL NOT PRESCRIBE CHRONIC PAIN MEDICATION(S) OR BENZODIAZEPINE(S)** (for example: chronic daily opiates). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.
3. Refills may take between 48 to 72 hours to process. You may need to be evaluated by your provider to obtain certain refills. ***(Initial here):***______

I authorize and consent to any diagnostic and/or medical treatment under the instruction of my attending physician. I understand that I will be expected to pay my portion for materials and services provided to me at the time of service. I authorize this office or its agent to release to my insurance company, and designated utilization review and/or quality assurance organization, any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

(Initial here):______

I have read and understand Ali‘i Health Center’s Notice of Privacy Practices and acknowledge that I have received a copy._______***(Initial here)***

I was presented, and declined a copy of Ali‘i Health Center’s Notice of Privacy Practices.______ (***Initial here)***

____ ____________________________

Patient or Legal Representative Signature Date

____ ____________________________

Witness Signature Date