QUEEN'S ISLAND URGENT CARE

**COVID-19 Registration Form**
**Tel: (808)735-0007**
**Fax: (808)735-0021**

## PATIENT INFORMATION

FIRST NAME: _____ M.I. _____ LAST NAME: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____ SSN: _____

## CONTACT INFO

EMAIL: _____ Phone: _____ □ Home □ Cell

PERMANENT MAILING ADDRESS (PLEASE INCLUDE APT, SUITE, OR UNIT #):

_____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

TEMPORARY ON-ISLAND ADDRESS (IF NOT FROM HAWAII):

_____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

## EMPLOYMENT

EMPLOYER NAME: _____ WORK PHONE:_____

EMPLOYER ADDRESS:

_____STE #: _____ CITY: _____ STATE: _____ ZIP: _____

BY SIGNING BELOW, I CERTIFY ALL THE INFORMATION PROVIDED ABOVE IS CORRECT AND I WISH TO RECEIVE MEDICAL CARE AND TREATMENT AT QUEEN'S ISLAND URGENT CARE. I CONSENT TO THE PROCEDURES THAT MAY BE PERFORMED DURING THIS VISIT.

**PATIENT/PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

**OFFICE USE ONLY**

DATE & TIME: _____ CLINIC LOCATION: _____

PATIENT ACCOUNT #: _____ STAFF INITIALS: _____