MOLOKA'I GENERAL HOSPITAL

PATIENT REGISTRATION

Patient Information:

Last Name: _____ First _____ M_____

Mailing Address _____City_____ State _____ Zip _____

Physical Address _____City_____ State _____ Zip _____

Ph (H) (____)_____Ph (W) (____)_____Cell Ph (___)_____SS# _____

Birth date _____ Sex _____ Marital Status_____ Race _____

Employer _____

Address _____City_____ State _____ Zip _____

Spouse / Nearest Relative _____ Relationship_____

Address _____City_____ State _____ Zip _____ Phone_____

Allergies _____ Reason for visit _____

Guarantor Information (Person responsible for bill):

Last Name: _____ First _____ M_____

Address _____City_____ State _____ Zip _____

Phone (H) _(____)_____ Ph (W) _(____)_____ SS# _____

Relationship _____ Birth date _____ Sex _____ Marital Status _____

Employer _____

Address _____City_____ State _____ Zip _____

Emergency Contact (Other Than Spouse/Nearest Relative):

Name _____ Relationship _____

Address _____City_____ State _____ Zip _____

Phone (H) (___)_____ Ph (W) (___)_____Cell (___)_____

Accident Related

Is this visit due to an accident? _____ If yes, date of accident _____

Auto Accident? _____Work Related? _____Other? _____

Insurance Information:

Primary Insurance_____

Member #_____Group #_____

Name of Member (Name on ins card) _____

Name of Subscriber _____Birth Date of Subscriber_____

Secondary Insurance_____

Member #_____Group #_____

Name of Member (Name on ins card) _____

Name of Subscriber _____Birth Date of Subscriber_____