PATIENT ADMISSION/REGISTRATION INFORMATION

PATIENT NAME: _____ , _____, _____
Last **First** **M.I.**

DATE OF BIRTH: _____ ***AGE***: _____ ***SEX***: ☐ M ☐ F ***SSN#:*** _____-_____-_____

RESIDENTIAL/PHYSICAL ADDRESS: _____

MAILING ADDRESS: (if different from Residential) _____

PHONE: Mobile/Cell _____ Home/Landline _____ Work _____

MARITAL STATUS: (circle one) ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

ARE YOU HEARING-IMPAIRED OR HARD OF HEARING?: ☐ Yes ☐ No ***ARE YOU VISUALLY-IMPAIRED?***: ☐ Yes ☐ No

ETHNICITY: (circle one) ☐ Hispanic/Latino ☐ Non-Hispanic ***PREFERRED LANGUAGE***: _____

↳ ***If Non-Hispanic, what is your ethnic background:*** _____ ***PART HAWAIIAN?*** ☐ Yes ☐ No

RACE: (circle one ☐ White ☐ Black ☐ Native American/Eskimo/Aleut ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ OTHER ☐ UNKNOWN

ARE YOU A CITIZEN OF: Federated States of Micronesia or Republic of Palau or the Marshall Islands: ☐ Yes ☐ No (***If YES, Circle which one***)

↳ ***If*** **not a citizen of above,** ***Citizen of (Country)*****:** _____

PCP (Primary Care Doctor): _____ ***Contact Info***: Phone: _____

EMERGENCY CONTACT #1 - NAME: _____ ***RELATIONSHIP***: _____

PHONE: Mobile/Cell _____ Home/Landline _____ Work _____

Is Emergency Contact hearing-impaired? ☐ Yes ☐ No ***Is Emergency Contact visually-impaired?*** ☐ Yes ☐ No

EMERGENCY CONTACT #2 - NAME: _____ ***RELATIONSHIP:*** _____

PHONE: Mobile/Cell _____ Home/Landline _____ Work _____

Is Emergency Contact hearing-impaired?: ☐ Yes ☐ No ***Is Emergency Contact visually-impaired?*** ☐ Yes ☐ No

EMPLOYER: _____ ***EMPLOYMENT STATUS***: _____

OCCUPATION/TITLE: _____ ***EMPLOYER PHONE***: _____

EMPLOYER ADDRESS: _____

ARE YOU A VETERAN?: ☐ Yes ☐ No ☐ Unknown ***RELIGION:*** _____

PRIMARY INSURANCE COMPANY

Name: _____ Policy ID# _____ Group: _____

Address: _____ Plan #: _____ Coverage Code: _____

Phone: _____ Eff. Date: _____ Expiration Date: _____

Subscriber Name (if not you): _____ Phone: _____ Sex: ☐ M ☐ F

Relationship to Patient: _____ Date of Birth: _____ SS#: _____

SECONDARY INSURANCE COMPANY

Name: _____ Policy ID# _____ Group: _____

Address: _____ Plan #: _____ Coverage Code: _____

Phone: _____ Eff. Date: _____ Expiration Date: _____

Subscriber Name (if not you): _____ Phone: _____ Sex: ☐ M ☐ F

Relationship to Patient: _____ Date of Birth: _____ SS#: _____