THE QUEEN'S HEALTH CARE CENTERS

PATIENT REGISTRATION FORM

POB 1: 1380 Lusitana St., #804, Honolulu, HI96813 | Ph. (808) 691-8962, Fax (808) 691-8967
POB 1: 1380 Lusitana St., #706, Honolulu, HI 96813 | Ph. (808) 521-8913, Fax (808) 537-3944
POB 3: 550 S. Beretania St., #401, Honolulu, HI 96813 | Ph. (808) 691-7744, Fax (808) 691-4005
HALEIWA: 66-125 Kamehameha Hwy., Haleiwa, HI 96712 | Ph. (808) 637-5087, Fax (808) 637-0942
HAWAII KAI: 377 Keahole St., Honolulu, HI 96825 | Ph. (808) 396-6675, Fax (808) 395-2104
KAPOLEI: 599 Farrington Hwy., #201, Kapolei, HI 96707 | Ph. (808) 691-7338, Fax (808) 691-7360
MILILANI: 95-1249 Meheula Pkwy., #129, Mililani, HI 96789 | Ph. (808) 623-2435, Fax (808) 623-1125

For more information, please visit our website at www.queens.org

Patient Name:		Birthdate:
Address:		Apartment Number:
City:	State:	Zip Code:
Home Phone: ( )	Business Phone: ( )	
Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Sex: M F	Marital Status: S M D W
School Name if a Full Time Student:		Student Status: FT / PT
Employer Name:	Position:	
Employer Address:		Phone: ( )
City:	State:	Zip Code:
Guarantor:		
Relationship to Patient:		Birthdate:
Address:		Apartment Number:
City:	State:	Zip Code:
Home Phone: ( )	Business Phone: ( )	
Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Sex: M F	Marital Status: S M D W
State:	Zip Code:	
Accident Information: ☐ Auto ☐ Workers' Comp ☐ Other		
Date of Accident/Injury:	Describe Injury:	
Workers' Comp Insurance Name:		Phone: ( )
Workers' Comp Ins Address:		
City:	State:	Zip Code:
Primary Insurance:		
Group Number:	Policy Number:	Plan:
Subscriber Name:	Gender: M F	Birthdate:
Subscriber Address:		SS#:
City:	State:	Zip Code:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Secondary Insurance:		
Group Number:	Policy Number:	Plan:
Subscriber Name:	Gender: M F	Birthdate:
Subscriber Address:		SS#:
City:	State:	Zip Code:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Tertiary Insurance:		
Group Number:	Policy Number:	Plan:
Subscriber Name:	Gender: M F	Birthdate:
Subscriber Address:		SS#:
City:	State:	Zip Code:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

PATIENT SIGNATURE / PATIENT'S REPRESENTATIVE **DATE** **RELATIONSHIP TO PATIENT**