WAIMĀNALO HEALTH CENTER

Patient Registration

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please CHECK ONE)*
☐ Male ☐ Female
☐ Choose not to disclose

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Sexual Orientation
☐ Lesbian, Gay or Homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else: _____
☐ Don't know
☐ Choose not to disclose

Physical Address	City	State	Zip Code

Mailing Address	City	State	Zip Code

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:
☐ Home Phone ☐ Cell Phone ☐ Day Phone ☐ E-Mail Address

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Housing Status: ☐ **Not Homeless** ☐ **Homeless:** ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Chicano ☐ Mexican American ☐ Not Hispanic/Latino ☐ Cuban ☐ Puerto Rican ☐ Not Reported ☐ Mexican ☐ Spanish (Or another Hispanic, Latino or Spanish Origin)

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race (CHECK ONE below that best describes you):

☐ Native Hawaiian	☐ Fijian	☐ Chuukese	☐ Filipino	☐ Portuguese	☐ White
☐ Other Pacific Islander	☐ Marshallese	☐ I-Kiribati	☐ Chinese	☐ Puerto Rican	☐ Chamorro
☐ Samoan	☐ Micronesian	☐ Kosraean	☐ Japanese	☐ Other Asian	☐ African American/Black
☐ Tahitian	☐ Palauan	☐ Yapese	☐ Vietnamese	☐ Asian Indian	☐ Native American
☐ Tongan	☐ Pohnpeian	☐ Korean	☐ Laotian	☐ All Other (Please specify): _____	

Employer/School Name:
☐ Employed ☐ Student ☐ Unemployed ☐ Retired
☐ Full-Time ☐ Casual ☐ Part-Time ☐ Retired

Occupation:

Family Size (includes self, spouse, & children under 18): _____

Family Income: $ _____ ☐ Monthly ☐ Annual

PARENT/LEGAL GUARDIAN or GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Physical Address	City	State	Zip Code

Mailing Address	City	State	Zip Code

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:
☐ Home Phone ☐ Cell Phone ☐ Day Phone ☐ Email Address

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Employer Name:
☐ Employed ☐ Student ☐ Unemployed ☐ Retired
☐ Full-Time ☐ Casual ☐ Part-Time ☐ Retired

Occupation:

Family Size (includes self, spouse, & children under 18): _____

Family Income: $ _____ ☐ Monthly ☐ Annual

Patient Registration

Patient Name: _____ MRN: _____

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**

PATIENT PORTAL

Patient Portal *is WHC's latest technology that allows you to schedule and view appointments, request medication refills, see lab results, communicate with your health care team, ask questions about your bill, and request your health record.*

Are you enrolled into Patient Portal? ☐ Yes ☐ No **If No, do you need assistance to enroll?** ☐ Yes ☐ No

ADVANCE DIRECTIVES

Do you have an Advance Directive? *(Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond)* ☐ Yes ☐ No

MARKETING & PROMOTIONS

How did you hear about us? (Check all that apply) ☐ Family/Friends ☐ Mailer ☐ Web Search ☐ Banner ☐ Social Media ☐ Print Ads ☐ Other (Please specify): _____

How do you want to stay updated on services and classes? (Check all that apply) ☐ Email ☐ Phone Call ☐ Patient Portal ☐ Text Message ☐ Mailer ☐ Other (Please specify): _____

_____ Initials

I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or organization to process claims on my behalf. I authorize payment of benefits to WHC for services rendered.

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

I authorize WHC to communicate via text, email, and phone call. Message & Data rates may apply. If I am not available, I give WHC consent to communicate a message which will identify the WHC service(s) and/or the date and time of my appointment(s). I may opt out at any time and will need to notify the Front Office.

_____ Initials

MINOR: I consent and authorize Waimānalo Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

_____ Initials

Patient was informed of Waimānalo Health Center's Rights & Responsibilities. Information is available on WHC's website and patient may request a hard copy at any time.

_____ Initials

Patient was informed of Waimānalo Health Center's Notice of Privacy Practices. Information is available on WHC's website and patient may request a hard copy at any time.

_____ _____

Patient or Legal Guardian's Signature Date Signed

_____ _____

Guarantor's Signature Date Signed

FOR OFFICE USE ONLY

Record #_____

Pt Status Type:	**Valid ID:**	**Insurance:**
☐ Inactive	☐ Scan ID	☐ Scan Card
☐ Scheduled	☐ Update NG Pt Picture	☐ Update Info/Card
☐ Non-WHC Active		
☐ Active		
☐ Dental Patient Only		

Collected By: _____ Date: _____ Entered By: _____ Date: _____

Patient Registration: INSURANCE

Patient Name: _____ MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

PRIMARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

WAIMĀNALO HEALTH CENTER

CONSENT FOR CARE

I,_____, the undersigned, hereby give Waimānalo Health Center my consent and permission to obtain historical information, perform physical examinations, order diagnostic tests and give such treatment as the Center physicians deem appropriate for my physical and/or mental health. I understand that this consent is for, but not limited to, obtaining detailed medical and social/psychiatric histories, performance of examinations of mouth, genitals, rectum and ears, repair of minor cuts, tuberculin skin tests, injection of local anesthetics and medications (such as insulin, epinephrine, etc.), injection of immunizations, and all other ordinary medical office procedures.

I understand that for major surgery or other major procedures (such as incision and drainage of abscesses, biopsies, or insertion of such devices as an IUD or LARC) special explanations will be made to me and special permission obtained from me or from an adult family member if I am physically or mentally impaired from giving such consent. In cases of emergency, I hereby give permission for the rendering of all such medical services deemed necessary to stabilize my condition if I am physically or mentally impaired and an adult family member is not readily available.

I understand that this consent extends to diagnostic tests and services rendered at the Waimānalo Health Center clinic, designated laboratories, X-ray facilities, emergency rooms, offices of specialists, and hospitals by Center physicians as deemed necessary for medical care.

This consent is for the ongoing health care of myself until I withdraw from the Waimānalo Health Center and is given voluntarily. By my signature I hereby certify that I am of legal age (18 years old or older) or am an emancipated minor by the definition of State laws.

I understand that I am not consenting to any experimental procedures nor to any tests solely for the purpose of research or scientific study.

I certify that I have read the above (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

_____

_____

_____

_____

Patient or Legal Guardian Signature

_____

Date

WAIMĀNALO HEALTH CENTER

APPOINTMENT KEEPING AGREEMENT

Patient Information

It is important to keep your medical appointment(s) and to be on time. At Waimānalo Health Center (WHC), our goal is to provide quality medical care in a timely manner. In our efforts to make your visit more comfortable and to minimize your wait time, we have updated and implemented the following policies and procedures.

A. Check-in Policy:

To ensure access and timeliness of medical care, the front office and medical team will inform you to arrive at your designated check-in time, to allow for registration and screening prior to your scheduled appointment time. You are encouraged to:

1. Call by 3:00 PM on the day prior to your appointment to notify us of any changes; and/or
2. If you may be late for your designated check-in time.

B. Late Arrival Policy

We understand that delays may happen, however, it is important to us to see all patients as timely as possible. Not arriving at your designated check-in time is considered late. Clock times on the WHC Front Desk computers will be used to validate ALL designated check-in times.

If you arrive late for your appointment, you may experience one of the following:

1. You may have to wait to be seen;
2. We will ask you to reschedule your appointment for a later time on the same day, or to another day;
3. We will ask you to reschedule to another provider on the same day if available; or
4. If no open appointments exist, you may wait to see if something becomes available (without any guarantees) to the provider's schedule
5. *Kukui Clinic (Behavioral Health) Only:* If you arrive late, you will be seen for the remainder of your scheduled appointment time.

C. Cancellation Policy

If you are not able to make your scheduled appointment, please call us at (808) 259-7948 by 3:00 PM on the day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 PM on Friday. Appointments are in high demand, and your early cancellation will give another person access to timely medical care.

1. If you are not able to speak to someone, please leave a message with your name, phone number, your appointment date/time and request for rescheduling or cancellation reason.
2. If you receive appointment text reminders, you may reply with an "X" to cancel your appointment.

D. No Show Policy:

All patients who miss three (3) appointments dates in a three-month period, will be considered a chronic no show. After the third missed appointment date, you will be placed on a "Same Day Only" status. You may return to a regular status at the end of the rolling three-month period.

Waimānalo Health Center is committed to providing exceptional care. Your help in keeping your appointments enables us to provide better and timelier care for you and all of our patients.

I have read and consent to these terms.

Print Patient Name	Print Legal Guardian Name	Relationship
Patient Signature (Parent/Legal Guardian if under 18)	Date	