KONA
COMMUNITY HOSPITAL
Care You Can Count On
Medical Oncology
79-1019 Haukapila Street • Kealakekua, HI 96750
808-322-6910 • 808-322-6918 (fax)

PATIENT REGISTRATION

Patient Information:

Name:_____ **Date of Birth:**_____ **Age:** _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Work phone:** _____

Cell Phone: _____ **E-mail:** _____

Social Security Number: _____ **Primary Language:** _____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

My primary care provider is: _____

Who referred you to this office: ☐ PCP ☐Hospital ☐Relative ☐Other: _____

Work Status: Employed ☐ **Unemployed** ☐ **Student** ☐ **Retired** ☐ **Disabled** ☐

Employer: _____

Pharmacy of Choice: _____

Lab of Choice and location: _____

Contact information:

Emergency Contact: _____ **Phone:** _____

It is OK to leave messages on my home phone: ☐**Yes** ☐**No** **Cell phone:** ☐**Yes** ☐**No**

Please list the names of those whom we may disclose your medical information to should they make a request on your behalf (spouse, parent, child, friend) _____

_____

Financial Responsibility:

Who is financially responsible for any charges: Self☐ **Parent**☐ **Guardian** ☐

Name of responsible person (if not patient)**:** _____

Address of responsible person: _____

Telephone of Responsible person: _____**Social Security #**_____

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Reviewed by: _____
Date: _____

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Patient: _____ Date of Birth: _____
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Insurance Information:

Primary Insurance Carrier: _____

Insureds Name: _____ Date of Birth: _____

Relationship to patient: _____ Amount of Co-pay: _____

Policy Number: _____ Group Number: _____

Employer (policy holder): _____

Secondary Insurance Carrier: _____

Insureds Name: _____ Date of Birth: _____

Relationship to patient: _____ Amount of Co-pay: _____

Policy Number: _____ Group Number: _____

Employer (policy holder)**: _____**

*****PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS AND IDENTIFICATION WITH AT EACH VISIT*****

I hereby authorize the Medical Oncology Clinic at Kona Community Hospital and its representatives to provide services to me and I authorize release of any medical and other pertinent information for the purpose of treatment and processing of my health insurance claims. I also authorize direct payment by my insurance to the Medical Oncology Clinic at Kona Community Hospital and understand that I am responsible for payment of all services, including deductible, co-payments and non-covered services. I understand and agree that I am responsible for any balance for services rendered regardless of my insurance status. I verify that the information provided here is accurate and I will notify the office immediately of any changes.

_____ _____

Signature of Patient/Parent/Guardian **Date**