MĀLAMA I KE OLA
HEALTH CENTER

❑ 1881 Nani St., Wailuku

Date: _____

Chart #: _____

(For Official Use Only)

Patient Information

Patient Name: _____ **Date of Birth:** _____
Last First MI

Preferred Name: _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

May we also contact you by Email?: ❑ Yes ❑ No **Email:** _____

Phone Number:
Home: _____
Cell: _____
Work: _____

Language Spoken: _____
❑ Patient Refused

Marital Status: ❑ Single ❑ Partnered ❑ Married ❑ Widowed ❑ Divorced
Gender: ❑ Male ❑ Female ❑ Trans male ❑ Trans female ❑ Other
Sexual Orientation: ❑ Lesbian/Gay ❑ Straight ❑ Bi-Sexual ❑ Something Else ❑ Do not Know ❑ Choose not to disclose
Preferred method of contact: ❑ Email ❑ Phone ❑ Letter
Veteran: ❑ Yes ❑ No

Race:
Asian
❑ *Japanese* ❑ *Chinese* ❑ *Vietnamese* ❑ *Laotian* ❑ *Filipino* ❑ *Korean*
Other Pacific Islander
❑ *Tongan* ❑ *Samoan* ❑ *Micronesian* ❑ *Marshallese*
❑ Native Hawaiian (Hawaiian, Part-Hawaiian)
❑ American Indian/Alaska Native
❑ Black/African American
❑ White
❑ Patient Refused

Ethnicity: (☑ Please check)
❑ Hispanic
❑ Non-Hispanic
❑ Patient Refused

Responsible Party Information

Guarantor Name: _____ **Date of Birth:** _____
Last First MI

Address: _____
Street City State Zip Code

Phone: _____ ❑ Home ❑ Work ❑ Cell

Relationship to patient: ❑ Spouse ❑ Child ❑ Other _____

Revised on 5/2/2019

Insurance Information

(Present Insurance card(s) to receptionist)

Do you have dental insurance? ❑ Yes *(complete insurance information below)* ❑ No

Primary

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other _____
(Any relationship other than self, complete subscriber information)

Insurance Plan Name: _____

Subscriber's ID#: _____

Secondary

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other _____
(Any relationship other than self, complete subscriber information)

Insurance Plan Name: _____

Subscriber's ID#: _____

Financial Information

(You may qualify for discounted services)

Number of people in your household: _____ **Gross monthly family income:** **$** _____

Homeless ❑ Yes ❑ No

If yes, please check one: ❑ Shelter ❑ Transitional ❑ Doubling up ❑ Street ❑ Other _____

Emergency Contact Information

Contact Name: _____ **Phone:** _____
Last First MI ❑ Home ❑ Work ❑ Cell

Relationship to patient: ❑ Spouse ❑ Child ❑ Other _____

Revised on 5/2/2019

PAYMENT POLICY:
Payment is expected at the time of visit. Please identify which option is your choice for payment:
❑ I will make payment at each visit.
❑ I will use my medical insurance and pay the co-payment, should there be one, at the time of visit.

ASSIGNMENT OF BENEFITS:
I assign my insurance benefits to the Mālama I Ke Ola Health Center. I understand that this assignment is valid for one year unless I cancel authorizations through written notice to the Mālama I Ke Ola Health Center.

AUTHORIZATION TO TREAT
I hereby authorize the medical staff of the Mālama I Ke Ola Health Center, to perform any and all diagnoses, procedures, and/or treatment as deemed necessary for the care and treatment of the patient for the condition for which I or members of my family have sought medical care. This authorization is effective today and will remain in effect until: the guardian/parent releases the patient from our care; the physician withdraws from care; or the patient releases him or herself from our care.

CONFIDENTIALITY/RELEASE OF MEDICAL RECORDS
Confidentiality/Protected Health Information: All patient health information is confidential unless the information is permitted or required to use or disclosed related to the following circumstances: treatment, payment, health care operations, research, organ and tissue donation, as required by law, to avert serious threat to health or safety, military and Veteran's services, Worker's Compensation, public health issues, health oversight, law enforcement, coroners, health examiners, funeral directors, National Security and Intelligence Activities and inmates. Patients may give or be asked to give authorization for release of information under other circumstances.

ACKNOWLEDGEMENT
I have read the above and I have received or been offered a copy of Mālama I Ke Ola Health Center's policies for the following:

*Notice of Privacy Practices
*Patient Rights and Responsibilities
*Your Advance Directive for Future Health Care pamphlet

Signed: _____ **Date:** _____

FOR STAFF USE ONLY:
I have received the following documents:

❑ ID received
❑ Birth Certificate received
❑ Copy of insurance card received
❑ Proof of Income received

Employee Initials: _____