HALEIWA FAMILY HEALTH CENTER

Pediatric Patient Information

Acct #_____

Patient Name:_____
(Last) (First) (M.I.)

Mailing/Mainland Address:_____

Street/Local Address:_____

Res. Phone:_(___) _____Daytime phone:_____Sex____Birth date_____

Student status: Full time_____ Part time_____SSN:_____

Father's Name:_____SSN:_____B/D_____
Employed by:_____Occupation:_____
Business address:_____Phone:_____

Mother's name:_____SSN:_____B/D_____
Employed by:_____Occupation:_____
Business address:_____Phone:_____

Responsible Party Other than Patient:_____Relationship to pt:_____
Billing address:_____

Medical Insurance(s):

	Name	Policy #	Subscriber	Relationship	DOB
(1)					
(2)					
(3)					

Nearest relative not living with patient:_____Relationship to pt_____
Address:_____Phone #:_____

Insurance Authorization – Please Read and Sign

I hereby authorize my doctor to furnish information to insurance carriers or government agencies concerning my illness and treatments . I also hereby assign to my doctor all payments for medical services rendered to my dependents or myself. I understand I am responsible for any amount not covered by insurance.

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature:_____Date:_____