Today's Date:_____

Patient Name:_____
Last Name First Name MI

DOB:_____ SSN No:_____ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

Physical Address:_____City:_____State:_____Zip Code:_____

Mailing Address:_____City :_____State:_____Zip Code:_____

Home Phone:_____Cell:_____ Are you a full time Student?: YES ☐ NO ☐

Patient Employer:_____Phone:_____EXT:_____Employment Status:_____

Emergency Contact:_____Phone:_____Relationship:_____

Guarantor:_____DOB_____Relationship:_____Phone:_____

Mailing Address:_____City:_____State:_____Zip:_____

Guarantor Employer:_____Phone:_____EXT:_____Employment Status:_____

Employer Address:_____City:_____State:_____Zip Code:_____

Email Address:_____

Do you have medical insurance? YES ☐ NO ☐ Self Pay ☐

* Primary Insurance:_____Subscriber:_____DOB:_____

Subscriber No:_____Group No:_____

Secondary Insurance:_____Subscriber:_____DOB:_____

Subscriber No:_____Group No:_____

Primary Care Physician:_____Phone:_____

Are you Hispanic or Latino? YES ☐ NO ☐ Race:_____ Primary Language:_____

Pharmacy:_____
Would you like to be web enabled for our patient portal? YES ☐ NO ☐ Email:_____
*The patient portal allows you access to your medical records, review lab reports, receive e-mail reminders of appointments, request appointments, and update demographics on your account. This is a great way to communicate with patients.

Authorization:
I authorize the medical staff of Maui Lani Physicians & Surgeons to administer such treatment as may be responsible or necessary in connection with the condition(s) for which I have sought medical care. Authorization is granted to release to my insurance carrier such information as may be necessary for the completion of my medical claims, this authorization shall remain in effect unless specifically rescinded or canceled in writing by the patient
Please review the HIPAA privacy information attached and initial box.

Print Patient Name:_____ DATE:_____

Patient or Authorized Signature:_____ Relationship:_____