ISLAND URGENTCARE

Kahala Hawaii Kai Kapahulu Pearl Kai Kakaako

New Patient

Date of Service_____ Time of Service _____Patient Acct#_____ **Demo Sheet**

Patient Information Date of Birth:_____ AGE:_____ Gender M☐ F☐

First:_____M.I._____Last:_____ Marital Status:_____

Also Known As / Maiden Name:_____ Social Security Number (SSN):_____

Permanent Mailing Address (Please include Apt, Suite, or Unit # needed for mailing):

_____City_____State_____Zip_____

Visiting Address:_____City_____State_____Zip_____

May we leave a message on the phone numbers provided? Yes☐ No☐ How did you hear about us?_____

Cell Phone #_____Home Phone #_____

We use technology to communicate electronically, including sending statements, receipts, and records via secure email.

***Email Address (please write clearly)_____ _____

Reason for visit / Symptoms _____Onset /Injury Date_____

Preferred Pharmacy_____ **Primary Care Physician**_____

Insurance Information (Please provide Receptionist with ALL medical insurance information) **CARDS PROVIDED** ☐

Primary Insurance_____

Policyholder's Name_____(Male/Female)

Date of Birth_____SSN_____

Relationship to Patient: Mother☐ Father☐ Spouse☐ Other_____

Secondary Insurance_____

Policyholder's Name_____(Male/Female)

Date of Birth_____SSN_____

Relationship to Patient: Mother☐ Father☐ Spouse☐ Other_____

Third Insurance_____

Policyholder's Name_____(Male/Female)

Date of Birth_____SSN_____

Relationship to Patient: Mother☐ Father☐ Spouse☐ Other_____

Responsible Party / Parent /Guardian(s) for minor patient (For patients under the age of 18. Please provide parent information below)

Patient or Legal Guardian: Relationship to Patient: Mother ☐ Father ☐ Other_____

First_____M.I._____Last_____

Date of Birth_____SSN_____

Primary Phone #_____

Mailing Address: Same as Patient☐

Other Mailing address:_____

City_____State_____Zip_____

***Email**_____

By signing below, I certify all information provided above is true and correct.

****ADMINISTRATION FEES**: If you do not provide an email, IUC will add a $25 administrative fee if there is any returned mail or rejected claims due to errors or omissions or illegible submissions in completing this form. (Sign below)

Patient/Parent/Guardian signature_____**Date of Service**_____

STAFF INITIALS_____