WAILEA MEDICAL CENTER
& Urgent Care

Name _____
Last First Middle

Date of Birth_____ Social Security_____ Sex_____

Mailing Address _____

_____
City State Zip Code

Cell phone #_____ Home phone #_____

Work #_____ Email _____

**** If voicemail is available, do you authorize Wailea Medical Center & Urgent Care to leave a detailed message regarding your healthcare at the number provided?** Yes No

Employer_____ Department/Title_____

Insurance Information:

Primary Insurance_____ Subscriber Date of Birth_____

Subscriber Name_____
Last First Middle

Emergency Contact / Significant Other Information:

Name_____
Last First Middle

Date of Birth_____ Relation to Patient_____ Sex_____

Primary phone #_____ Cell Home Work

Secondary phone #_____ Cell Home Work

**** Do you authorize the release of medical information regarding your healthcare to this person?** Yes No

By signing below you are indicating that you understand & agree to the terms and office policies

- I received a copy and or the opportunity to review the Notice of Privacy Practices and Office Policies.
- I understand that Wailea Medical Center & Urgent Care is a private practice and may choose which medical insurances they wish to participate with.
- I understand that Wailea Medical Center & Urgent Care will attempt to verify eligibility for insurances with which they participate.
- In the instance that Wailea Medical Center & Urgent Care cannot verify a patient has active medical insurance and or the insurance will not cover the services requested, I understand that I am responsible and agree to pay for any and all charges.
- I understand and agree that insurance is not a guarantee of payment, in the instance that Wailea Medical Center & Urgent Care submit any charges incurred at this facility to my insurance company and the insurance company does not cover said charges, I am responsible for any and all outstanding balances.
- I understand and agree that Wailea Medical Center & Urgent Care will collect my estimated patient share also known as copay at the time of service, and that the copay is subject to change at any time due to my insurance company.
- I understand and agree that if I am unable to pay my copay at the time of service, I will be responsible for the $5.00 surcharge.
- I understand and agree that in the instance that Wailea Medical Center & Urgent Care does not participate with a patient's insurance, I am obligated to place a deposit of $100.00 cash or copy of a valid credit card before any services will be provided.
- A $25 office charge will be assessed if you do not show up to a scheduled appointment.

If the Patient is Under the Age of 18:

Guardian: _____
Last First Middle

Date of Birth _____ Relation to Patient _____

Sex _____ Primary phone #_____ Cell Home

Print Name_____

Signature _____ Date_____

Medical History:

Do you drink alcohol? Yes No How Frequently_____

Do you use tobacco or tobacco products? Yes No How Frequently_____

If you no longer smoke, how long have you quit? _____

Do you have a history of substance abuse? Yes No How Frequently_____

Do you have a history of domestic violence? Yes No How Frequently_____

Do you exercise? Yes No How Frequently_____

Are you on a special diet? Yes No Please Explain:_____

List all Allergies that you are aware of:_____

_____

List all Medications and the dosage that you are currently taking:_____

_____

List previous surgeries or hospitalizations, please indicate dates:_____

_____

Medical conditions past or present:

__Anemia
__Arthritis
__Asthma
__Birth Defect
__Cancer
__Depression
__Diabetes
__Epilepsy
__Heart Disease
__Hepatitis
__Headache
__HIV
__High Blood Pressure
__High Cholesterol
__Kidney Dysfunction
__Liver Dysfunction
__Mental Illness
__Sexually Transmitted Diseases
__Stomach Dysfunction
__Stroke
__Thyroid Dysfunction
__Tuberculosis
__Other_____

Family History: List any known medical problems.
Example: stroke, heart disease, diabetes, cancer, or high blood pressure*

Father:_____

Mother:_____

Sibling:_____

How did you hear about Wailea Medical Center & Urgent Care: _____

Patient Name_____ Date of Birth_____

Signature _____ Date_____