KAPI`OLANI BEHAVIORAL HEALTH SERVICE
PATIENT REGISTRATION RECORD

PATIENT INFORMATION (Please print clearly)	
Last Name	First Name, M.I.
SSN	Sex: (M/F)
DOB/Age	Marital Status
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.; Cellular/Pager
Employer/School-Grade	Ethnicity
Primary Care Physician	Referred By

PERSON RESPONSIBLE FOR BILL	
Last Name	First Name, M.I.
Mailing Address	City, State ZIP
Home Phone	Work Phone/Ext.

MEDICAL INSURANCE	
PRIMARY INS PLAN	MEMBERSHIP #
SUBSCRIBER LAST NAME, FIRST NAME (If other than patient)	SUBSCRIBER'S DOB GENDER: (M/F)
SSN	EMPLOYER
SECONDARY INS PLAN	MEMBERSHIP#
SUBSCRIBER LAST NAME, FIRST NAME	SUBSCRIBER'S DOB GENDER: (M/F)
SSN	EMPLOYER

EMERGENCY CONTACT	
Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.
Relationship to Patient	

IF PATIENT IS A MINOR (AGE 18 & UNDER)	
PRIMARY CONTACT Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.
Relationship to Patient	
MARITAL STATUS OF PARENTS:	(If divorced or separated, please bring copy of legal documents on custody arrangement to the first visit)
MOTHER Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.
Employer	
FATHER Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.
Employer	
CHILD'S LEGAL GUARDIAN Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.
Employer	
FOSTER MOTHER Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.
SOCIAL WORKER Last Name	First Name, M.I.
Home Address	City, State ZIP
Home Phone	Work Phone/Ext.

7/9/09