Pali Women's
HEALTH CENTER
642 Ulukahiki St. #305
Kailua, HI 96734

PATIENT INFORMATION

NAME_______________________________________ DATE OF BIRTH________________________________

RACE________________ETHNICITY______________LANGUAGE SPOKEN_______________________________

ADDRESS____

CITY___________________________________STATE______________ ZIP CODE__________________________

MAILING ADDRESS (if different)____

CITY___________________________________STATE______________ZIP CODE___________________________

S.S#____________________________________ HOME PHONE____

WORK PHONE___________________________ CELL PHONE____

REFERRED BY_______________________________________MARITAL STATUS____________________________

EMPLOYER____

WORK ADDRESS____

OCCUPATION____

SPOUSE'S EMPLOYER_____________________________ PHONE #_____________________________________

NAME OF INSURANCE____

ADDRESS____

I.D #_______________________________________ GROUP #____

POLICY HOLDER'S NAME____EMPLOYER INS (Y/N)________________

RELATIONSHIP TO PATIENT__________________________________ INSURED'S DOB______/________/________

IF UNDER 18- PARENTS SIGNATURE____

SECONDARY INSURANCE____

ADDRESS____

I.D#____GROUP#____

POLICY HOLDER'S NAME___________________________________INSURED'S DOB______/________/_______

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME_______________________________________ PHONE #____

ADDRESS____

RELATIONSHIP TO PATIENT____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I also authorize payment from my insurance company to be made directly to PALI WOMENS HEALTH CENTER.
I hereby agree that if payment on my account is not made in full when due, I agree to be responsible for all collection costs including attorney's fees.
Except for collection actions against me, I agree that any controversy or claim arising out of or relation to the Physician/patient relationship herein, or the breach thereof, shall be settled by Arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association and judgment thereof. I understand that by agreeing to Arbitration, I am waiving my rights to a jury trial.

SIGNATURE____ DATE____________________________