THE QUEEN'S HEALTH CARE CENTERS

Care you can trust

PATIENT REGISTRATION FORM

HAWAII KAI CENTER
377 Keahole Street
Honolulu, Hawaii 96825
Ph. (808) 396-6675
Fax (808) 395-2104

KAPOLEI CENTER
599 Farrington Hwy., #201
Kapolei, Hawaii 96707
Ph. (808) 674-9500
Fax (808) 674-9436

DOWNTOWN CENTER
550 South Beretania St. # 401
Honolulu, Hawaii 96813
Ph. (808) 691-7744
Fax 691-4005

For more information, please visit our website at www.queens.org

Patient Name:		Birthdate:
Address:		Apartment Number:
City:	State:	Zip Code:
Home Phone: ( )	Business Phone: ( )	
Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Sex: M F	Marital Status: S M D W
School Name if a Full Time Student:		Student Status: FT / PT
Employer Name:	Position:	
Employer Address:		Phone: ( )
City:	State:	Zip Code:
Guarantor:		
Relationship to Patient:		Birthdate:
Address:		Apartment Number:
City:	State:	Zip Code:
Home Phone: ( )	Business Phone: ( )	
Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Sex: M F	Marital Status: S M D W
State:	Zip Code:	
Accident Information: ☐ Auto ☐ Workers' Comp ☐ Other		
Date of Accident/Injury:	Describe Injury:	
Workers' Comp Insurance Name:		Phone: ( )
Workers' Comp Ins Address:		
City:	State:	Zip Code:
Primary Insurance:		
Group Number:	Policy Number:	Plan:
Subscriber Name:	Gender: M F	Birthdate:
Subscriber Address:		SS#:
City:	State:	Zip Code:
Patient's Relationship to Subscriber: ☐ Self	☐ Spouse ☐ Child ☐ Other:	
Secondary Insurance:		
Group Number:	Policy Number:	Plan:
Subscriber Name:	Gender: M F	Birthdate:
Subscriber Address:		SS#:
City:	State:	Zip Code:
Patient's Relationship to Subscriber: ☐ Self	☐ Spouse ☐ Child ☐ Other:	
Tertiary Insurance:		
Group Number:	Policy Number:	Plan:
Subscriber Name:	Gender: M F	Birthdate:
Subscriber Address:		SS#:
City:	State:	Zip Code:
Patient's Relationship to Subscriber: ☐ Self	☐ Spouse ☐ Child ☐ Other:	

PATIENT SIGNATURE / PATIENT'S REPRESENTATIVE **DATE** **RELATIONSHIP TO PATIENT**