QUEEN'S NORTH HAWAI'I COMMUNITY HOSPITAL

QUEEN'S NORTH HAWAI'I COMMUNITY HOSPITAL PATIENT REGISTRATION SHEET

NAME: LAST	**FIRST**	**MIDDLE**	
DATE OF BIRTH:	**AGE:**	**SEX:** M ☐ F ☐ T ☐	**SOCIAL SECURITY NUMBER:**
PHONE: HOME	**PHONE: WORK**	**PHONE: CELL**	
EMAIL:			
MARITAL STATUS:	SINGLE ◯	MARRIED ◯	WIDOWED ◯ SEPARATED ◯ DIVORCED ◯
ETHNICITY:	HISPANIC LATINO ◯	NOT HISPANIC/LATINO ◯	NOT REPORTED ◯
RACE:	AMERICAN INDIAN OR NATIVE ALASKAN ◯	ASIAN ◯	BLACK OR AFRICAN AMERICAN ◯ NATIVE HAWAIIAN OR PACIFIC ISLANDER ◯ WHITE ◯ NOT REPORTED ◯
PHYSICAL ADDRESS:	**CITY**	**STATE**	**ZIP CODE**
MAILING ADDRESS:	**CITY**	**STATE**	**ZIP CODE**
PREFERRED LANGUAGE:		**OCCUPATION:**	
PRIMARY CARE PHYSICIAN:			
EMERGENCY CONTACT:			
RELATIONSHIP	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**
RELATIVE OR LEGAL GUARDIAN:			
RELATIONSHIP	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**
MILITARY VETERAN:	**YES** ◯	**NO** ◯	
EMPLOYER NAME & ADDRESS:	**EMPLOYMENT STATUS**	FULL-TIME ◯ PART-TIME ◯ RETIRED ◯ NOT EMPLOYED ◯ SELF EMPLOYED ◯	
RETIREMENT DATE:			
PRIMARY INSURANCE:			
POLICY #:	**GROUP #:**		
SUBSCRIBER NAME:	**SUBSCRIBER SEX:**	**SUBSCRIBER DOB:**	**GUARANTOR:**
RELATIONSHIP TO PATIENT:			

SIGNATURE _____ DATE: _____

IF MINOR, PARENT/GUARDIAN SIGNATURE _____ DATE: _____