Hawai'i Island Community Health Center

PEDIATRIC PATIENT INFORMATION

Please fill in all information requested, as it helps us to better serve you.

Please be assured that patient information is confidential, and is only used for Hawai'i Island Community Health Center purposes.

PEDIATRIC PATIENT INFORMATION SUMMARY

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Mailing Address: _____ City: _____ State/Zip: _____

Street Address:* _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ * *Required for prescriptions*

Please select preference for appointment reminders: Preferred Phone: ☐ Home ☐ Cell Preferred Method: ☐ Voice ☐ Email ☐ Text

Patient's Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Race:
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native American Indian/Alaskan Native
- ☐ More than one race

Ethnicity:
- ☐ Latino/Hispanic
- ☐ Not Latino/Hispanic

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Marshallese
- ☐ Russian
- ☐ Filipino
- ☐ Chinese
- ☐ Japanese
- ☐ Sign Language

Would you like to have an interpreter?
☐ Yes ☐ No

Patient's Employment Status: ☐ Employed ☐ Unemployed ☐ Part-Time Student ☐ Full-Time Student

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PERSON(S) RESPONSIBLE FOR PAYMENT

The guarantor is the parent or guardian for patients under 18 years of age, and is the patient him or herself from 18 years of age and up.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

HOUSEHOLD AND FINANCIAL INFORMATION

Please complete the information requested below. Your responses in these two sections help us receive grant funding to provide health care services for our community. In addition, this information may help you qualify to receive additional benefits, such as a Sliding Fee Scale, or discounts on medication or other services.

Be assured that your personal, identifiable information is never reported.

Family Size: _____

Monthly Gross Family Income:

☐ No income ☐ $2,500-$3,000

☐ $100-$500 ☐ $3,500-$4,000

☐ $500-$1,000 ☐ $5,500-$6,000

☐ $1,500-$2,000 ☐ Other (please specify): _____

PATIENT INFORMATION

Farm Worker Status: ☐ Migrant ☐ Seasonal ☐ Not a Farm Worker

Public Housing: ☐ Yes ☐ No

Disabled: ☐ Yes ☐ No

Homeless: ☐ No ☐ Transitional Housing ☐ Homeless Shelter ☐ Street ☐ Other

Refugee Status: ☐ Yes ☐ No If "Yes," what is your country of origin? _____

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PEDIATRIC PATIENT INFORMATION

INSURANCE INFORMATION (Please provide a copy of all insurance cards.)

Primary Insurance Co.: _____ **ID#:** _____

Patient's Relationship to Subscriber/Member: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber/Member:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State/Zip: _____

Secondary Insurance Co.: _____ **ID#:** _____

Patient's Relationship to Subscriber/Member: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber/Member:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State/Zip: _____

ALTERNATE CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Phone: _____ May we speak to this person about the Patient's health? ☐ Yes ☐ No

May we speak to anyone else about the Patient's health? ☐ Yes ☐ No If "Yes," Name: _____

Relationship: _____ Phone Number: _____

Parent/Legal Guardian (if under 18 years of age):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Pediatric Patient's Mother's Maiden Name: _____

Do you have a current Advance Directive? ☐ Yes ☐ No

If "Yes," please provide us with a copy of your Advance Directive.
If "No," an Advance Directive Form is available to you upon request.

I decline to provide/discuss Advance Directives: ☐ Yes ☐ No

PERMISSION AND RELEASE

Please review the following statements, and indicate your agreement with them by signing below.

- I do not have Kaiser. (Hawai'i Island Community Health Center does not participate with Kaiser.)
- If we do not participate with your insurance provider (such as Kaiser), you are responsible for full payment.
- I have accurately disclosed all information about my finances (money) and insurance.
- I am responsible to notify Hawai'i Island Community Health Center about any changes in finances or insurance coverage.
- I authorize Hawai'i Island Community Health Center, its providers and staff, to provide insurance companies with any information needed to receive payment for my visits. My signature below may be used on all insurance forms.
- I give permission to Hawai'i Island Community Health Center to share my information among all of its groups (medical, dental, behavioral health, health education, case management) so that my family and I can receive the best care.
- I authorize Hawai'i Island Community Health Center to send appointment reminders to me via voice call, text messages, and/or email.
- Today's co-pay or charges are a minimum payment for your visit. Any additional charges that are not covered by your insurance will be billed to you. **I understand that I am responsible for the balance due after insurance and/or the sliding fee scale have been applied.**
- **I understand that Hawai'i Island Health Center does not accept Worker's Compensation and No-Fault (MVA) insurance. If either of these is applicable to my situation, I will disclose this to Hawai'i Island Community Health Center so that I can be referred to a doctor in the community who can see me.**
- **All of the information that I am presenting is correct and complete.**

By signing here, I acknowledge my agreement with the above statements, permissions, and releases:

Signature (Patient/Person Responsible/Legal Guardian): _____

Print Name: _____ **Date:** _____

Witness Signature (if other than the Patient has signed above): _____

Print Witness Name: _____ **Date:** _____