



THE MEDICAL CORNER

web site: www.themedicalcorner.com

AIRPORT KAPOLEI

KAILUA WAIKIKI

Other _____

Registration Form

Patient Information

BADGE #

I.D. #

Patient's name (last, first, middle)	Sex <input type="checkbox"/> female <input type="checkbox"/> male	Birthday	Social Security #
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Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> widowed	E-mail
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Patient's home address	Apt. #	City	State	Zip Code
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Patient's home phone	Patient's work phone	Employment status <input type="checkbox"/> full time <input type="checkbox"/> part time	Student status (if applicable) <input type="checkbox"/> full time <input type="checkbox"/> part time	Employer / School
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Occupation / Date Employed	Family physician referred by:
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Referred by: Name	Address
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How did you hear about us?

Midweek Penny Saver TV Yellow Pages Friend Shopping cart
 Window News paper Radio Theater Flyer Church Bulletin

Other (please list) _____

Emergency/Other Contact Information

Name of emergency contact (last, first, middle)	Relation to patient	Home phone	Work phone
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Emergency contact (not living with you): Name:	Relation to patient	Home phone	Work phone
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If not an Oahu resident, provide an Oahu address where you may be contacted	Contact phone
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Person Responsible for bill (if other than patient)

Name (last, first, middle)	Social Security #	Home phone	Work phone
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Responsible party's mailing address	Apt. #	City	State	Zip Code
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Foreign Counter (if applicable)	Patient's relationship to person responsible for bill
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Employer (person responsible)	Occupation	Date employed	Work phone
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Employer (spouse)	Occupation	Date employed	Work phone
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Patient's name (last, first, middle)			Social Security #	
Insurance Carrier # 1		Membership # /Policy #		Group #
Subscriber's name (last, first, middle)		Subscriber's birthdate	Patient's relationship to subscriber <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	
Effective date (if known)	Expiration date (if known)	For Champus patients only: Branch of Service: <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine		Champus patients only: Status <input type="checkbox"/> active <input type="checkbox"/> retired <input type="checkbox"/> deceased
Insurance Carrier # 2		Membership # /Policy #		Group #
Subscriber's name (last, first, middle)		Subscriber's birthdate	Patient's relationship to subscriber <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	
Effective date (if known)	Expiration date (if known)	For Champus patients only: Branch of Service: <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine		Champus patients only: Status <input type="checkbox"/> active <input type="checkbox"/> retired <input type="checkbox"/> deceased

RELEASE OF INFORMATION

I hereby authorize **Acute Care Medical Services, Inc.**, dba **The Medical Corner**, to release any and all medical records and other information in its possession necessary to confirm charges for service to all parties with legitimate interest in that information. Parties with a legitimate interest may include other physicians of hospitals, insurance companies, prepaid health care contractors, workers' compensation carriers, professional review organizations or others. This authorization will remain effective until revoked by me in writing.

Signed: _____ Dated: _____

AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby consent and authorize the administration of all treatments that may be considered advisable or necessary in the judgement of the physician.

Signed: _____ Dated: _____

ACKNOWLEDGMENT

I acknowledge that all information contained on this form is true and accurate. I further agree that I have read the above statements and understand everything in these statements. I intend and agree to be bound by all of the terms of this agreement.

Signed: _____ Dated: _____