This form is to be completed either by the Patient or his/her guardian.

Hilo Medical Center
We Care for Our Community

REGISTRATION / ADMISSION WORKSHEET

YOUR ADMITTING DOCTOR ____________________ DATE OF ADMISSION ____________

TYPE OF ADMISSION: Short Stay Outpatient Inpatient OB LMP Date: ____________

FOR OFFICE USE ONLY:
Acct # ____________ Med Rec# ____________

PLEASE CHECK THE CORRECT ANSWER OR FILL IN THE BLANKS AS COMPLETELY AS POSSIBLE:

Name (Last, First, MI:) ______________________________

Maiden or other names used: ______________________________

Local (Mailing) Address: ____________________ City: ____________ State:
Zip: ____________ Phone # ____________

Street (if different) Address: ____________________ City: ____________ State:
Zip: ____________

Are you a Veteran? Do you wish to apply for VA benefits at this time?

(if Yes, answer questions below)

Date of Military service? ____________ Branch of Service? ____________

Are you a service connected VET? Claim# ____________

Sex (M or F): ______ Birthdate: ____________ Patient's Birthplace: ____________ Age:_____

Marital Status (Check One):

S	Single	M	Married	D	Divorced
W	Widowed	X	Separated	U	Unknown

Race (Check One):

A	Am.Indian/Eskimo	J	Japanese	Q	Hispanic
B	Black	K	Korean	S	Polynesian
C	Chinese	O	Other Asian/Pacific Islander	W	Caucasian
F	Filipino			X	Other
H	Hawaiian	P	Part Hawaiian		

Social Security Number: ____________

Religion (Check One):

AD	Adventist	EP	Episcopalian	OX	Other
AS	Assembly of God	JE	Jewish	PN	Pentecostal
BD	Buddhist	JW	Jehovah Witness	PR	Presbyterian
BP	Baptist	LU	Lutheran	PS	Protestant
CA	Catholic	ME	Methodist	UC	United Church of Christ
CC	Church of Christ	MO	Mormon (LDS)		
CH	Christian	NO	None	XX	Unknown

Have you assigned anyone Durable Power of Attorney for your medical care? Yes No
Durable Power of Attorney: Name ____________________ Relationship ____________
Address ______________________________ Phone ____________

Do you have a medical Living Will? Yes No

****Note: If you have these documents, please bring them in and inform the Admissions office staff or Nursing Unit.**

WOULD YOU LIKE YOUR NAME WITHHELD FROM THE RELIGIOUS LIST? YES NO
WOULD YOU LIKE YOUR NAME & LOCATION WITHHELD FROM THE PUBLIC? YES NO

GUARANTOR INFORMATION: Person responsible for bill. (self, parent-if patient is a minor)

Name: ______________________ Relationship to patient: ______________

Employment Status of Guarantor:

F	Full Time	P	Part Time	S	Self Employed
M	Active Military	R	Retired	U	Unemployed
D	Disabled	N	Not Known		

Guarantor's Occupation: ______________________

Guarantor's Employer: ______________________

Employer's Address: ______________________ Employer's Phone No: ______________

Guarantor's Address : ______________________

Guarantor's Phone No.: ______________ Social Security No: ______________ Birthdate: __________

If patient is a minor, include parent's social security number.

Spouse's Name: ______________________

Spouse's Address: ______________________ Phone: ______________

Nearest Relative's Name: ______________________

Relationship: ______________ Address: ______________________

Relative's Phone No: Home: ______________ Business: ______________

In case of Emergency, contact: ______________________

Relationship: ______________ Address: ______________________

Contact's Phone No.: Home: ______________ Business: ______________

Patient's Father's Name: ______________________

Patient's Mother's Name: ______________________

****Note: Only required for minor patients.**

INSURANCE INFORMATION

Company: ______ Membership No. : ______
Group Number: ______ Plan/Medical Coverage Code: ______
Subscriber Name: ______ Sex: ______
Subscriber Address: ______
Phone Number: ______ Relationship: ______
Subscriber Social Security No.: ______ Subscriber Birthdate: ______
Employment Status (Check One):

F	Full Time	R	Retired
P	Part Time	U	Unemployed
M	Active Military	N	Unknown
S	Self Employed	D	Disabled

Employer: ______ Address: ______ Phone: ______

Company: ______ Membership No. : ______
Group Number: ______ Plan/Medical Coverage Code: ______
Subscriber Name: ______ Sex: ______
Subscriber Address: ______
Phone Number: ______ Relationship: ______
Subscriber Social Security No.: ______ Subscriber Birthdate: ______
Employment Status (Check One):

F	Full Time	R	Retired
P	Part Time	U	Unemployed
M	Active Military	N	Unknown
S	Self Employed	D	Disabled

Employer ______ Address ______ Phone ______

Company: ______ Membership No. : ______
Group Number: ______ Plan/Medical Coverage Code: ______
Subscriber Name: ______ Sex: ______
Subscriber Address: ______
Phone Number: ______ Relationship: ______
Subscriber Social Security No.: ______ Subscriber Birthdate: ______
Employment Status (Check One):

F	Full Time	R	Retired
P	Part Time	U	Unemployed
M	Active Military	N	Unknown
S	Self Employed	D	Disabled

Employer ______ Address ______ Phone ______

This section is for AUTO ACCIDENT, WORKMAN'S COMP, OR OTHER ACCIDENTS

Is this visit accident related? Yes No
Date of accident: ______ Time of accident: ______
Where did accident occur? ______

IF WORKMAN'S COMPENSATION:

Employer at the time of injury? ______ Business Address: ______
Business Phone No.: ______
Insurance Company: ______