Patient Information

Welcome to Advanced Reproductive Center of Hawai'i. Please take a moment to provide the information requested below so our team can better serve you.

Advanced Reproductive Center *of* Hawai'i

Patient Information

I am: ☐ Single ☐ Married ☐ Divorced ☐ Widow

LAST NAME, FIRST NAME | EMAIL | BIRTHDATE

HOME ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE

MAILING ADDRESS | CITY | STATE | ZIP CODE | CELL PHONE

ETHNICITY *This information is voluntary, but greatly appreciated.*

Employer Information

EMPLOYER | OCCUPATION

EMPLOYER'S ADDRESS | BUSINESS PHONE

Spouse Information

SPOUSE'S NAME | OCCUPATION | SPOUSE'S BIRTHDATE

SPOUSE'S EMPLOYER | SPOUSE'S SOC. SEC.# *For Tricare patients only*

SPOUSE'S EMPLOYER'S ADDRESS

SPOUSE'S CELL PHONE | SPOUSE'S BUSINESS PHONE

Emergency Contact *In case of emergency, notify:*

NAME OF EMERGENCY CONTACT | RELATIONSHIP

HOME PHONE | BUSINESS PHONE

How did you hear about us? *Check all that apply*

☐ Doctor ☐ Friend ☐ Internet search ☐ Website

PLEASE SPECIFY WHICH SITE

Kapi'olani Medical Center for Women & Children
1319 Punahou Street, Suite 1180, Honolulu, Hawai'i 96826
Ph: **(808) 949-6611**

Fax: **(808) 949-6610**
arch@archawaii.com

Patient Information *Insurance and Authorizations*

All professional services rendered are charged to the patient.
The patient is responsible for all fees regardless of insurance coverage.

Advanced Reproductive Center *of* Hawai'i

Insurance Information

	TYPE OF INSURANCE	MEMBERSHIP / POLICY #	GROUP #	COVERAGE CODE	EFFECTIVE DATE	PLAN SUBSCRIBER
1						
2						

Is this insurance plan through your employer? ☐ Yes ☐ No

Insurance authorization and assignment *Please read and sign*

I hereby authorize Advanced Reproductive Center of Hawai'i to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician/s all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE _____ DATE _____

REFERRED BY _____

Appointment notice *Please read and sign*

Office appointments are limited and therefore in consideration to other patients, if you are unable to keep your appointment please notify our office as soon as possible. A $25.00 late cancellation fee will be billed if you do not provide us with 24-hour notice for your cancellation or if you fail to show up for your appointment.

There will also be a $25.00 service charge on all checks returned from your bank due to insufficient funds.

SIGNATURE _____ DATE _____

Contact authorization *Please read and sign*

Unless I request confidential communications, or that communication be made by alternative means (such as sending correspondence to my work address instead of my home), I hereby authorize the Advanced Reproductive Center of Hawai'i to leave detailed messages on the phone number(s) that I provided to them, mail correspondence to the address that I provided to them, and send emails to the email address I provided to them. I understand that it is my responsibility to request confidential communications from the Advanced Reproductive Center of Hawai'i and that this request must be made in writing.

SIGNATURE _____ DATE _____

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