HO'OLA LAHUI HAWAI'I
PHARMACY FITNESS CENTER
KAUA'I COMMUNITY HEALTH CENTER

HO'OLA LAHUI HAWAI'I
KAUA'I COMMUNITY HEALTH CENTER
Dental Services
Client Registration Form

Print Form

Fill out the information on this form on your computer & then print out and bring it with you to your appointment.

Ho'ola Cares

If you are uninsured, you may apply for a discount according to your family size and income amounts. If you qualify, you would pay a percentage of any billable charges. If you are interested in this discount, please inform us.

CLIENT / PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI ____ Preferred Name _____

Gender ☐ Male ☐ Female ☐ Other **Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐ Other

RACE (SELECT ONE ONLY)		
☐ American Indian or Alaska Native	☐ Asian	
☐ Native Hawaiian	☐ White	☐ Black or African American
☐ Other Pacific Islander (Guam, Samoa, (Other than Hawaiian)	☐ I do not wish to report this	

ETHNICITY (SELECT ONE ONLY)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ I do not wish to report this

Primary Language (SELECT ONE ONLY)

☐ English ☐ Other

Specify Other _____

☐ Check Box If you need a translator

Family Monthly Income: **(Please check one box)**		
☐ $0 - $1,223	☐ $1,224 - $1,688	☐ $1,689 - $1,835
☐ $1,836 -$2,447	☐ $2,448 - $3,058	☐ $3,059 and above
Family Size: ____	☐ I do not want to disclose Income Information	

Ho'ola Cares Program - **(TO BE COMPLETED BY DENTAL STAFF)**

☐ SFS A ☐ SFS B ☐ SFS C ☐ SFS D ☐ SFS E ☐ SFS F

Worker Status
☐ Migrant Worker
☐ Seasonal Worker

Are you a Veteran? ☐ Yes ☐ No

Housing Status
☐ Public ☐ Non-Public

Homeless Status
☐ Not Homeless ☐ Transitional
☐ Doubling up ☐ Street
☐ Other ☐ Unknown
☐ Homeless Shelter

Date of Birth _____ Age _____

Social Security # _____

Driver's License # _____

Street Address (City, State & Zip Code) _____

Mailing Address (City, State & Zip Code) _____

E-Mail _____ Home Phone _____ Work Phone _____ Cell Phone _____

Alias Last, First Name _____

(Patient's) Mother's Maiden Name (Last, First MI) _____

☐ No Phone Calls	☐ No Correspondence	☐ Disclosure Restrictions
☐ Check If Ok to leave message at your Home Phone	☐ Check If Ok to leave message on Cell Phone	☐ Check Box If Ok to leave message at Work Phone

Referred By: _____

EMERGENCY CONTACT INFORMATION:

List Person we may contact in case of emergency (If possible, someone from outside the home.

Who may we talk to about your health? Next of Kin

Name: _____ Relationship: _____ Phone No.: _____

Name: _____

Relationship: _____ Phone No.: _____

Name of Medical Physician _____

PARENT INFO (IF MINOR)

MOTHER NAME _____ PHONE# _____ EMAIL _____

FATHER NAME _____ PHONE# _____ EMAIL _____

Student Status (Select One)

☐ Part Time Student
☐ Full Time Student

Employment Status (Select One)

☐ Full Time	☐ Part Time	☐ Not Employed
☐ Self Employed	☐ Retired	☐ Active Military

Employer Name _____

☐ Self Pay (Please check here if you do not want an insurance claim submitted and wish to pay for entire services rendered at time of service.

PRIMARY DENTAL Insurance Information: (A copy of all insurance cards are required) ☐ None

Primary Insurance:		Membership ID #		Group #	
Subscriber Name:		Date of Birth:		SSN	

SECONDARY DENTAL Insurance Information: (A copy of all insurance cards are required) ☐ None

Secondary Insurance:		Membership ID #		Group #	
Subscriber Name:		Date of Birth:		SSN	

PRIMARY MEDICAL Insurance Name: (Please provide information to Front Reception) ☐ None

Name of Primary **Medical** Insurance Cov	

RESPONSIBLE PARTY INFORMATION

Relationship To Client/Patient: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

Name: _____	Relation to Patient _____	Contact Phone # _____
Mailing Address: _____	City: _____	Zip Code: _____

Ho'ola Lahui Hawai'i - Authorization and Release Form

I authorize this office to release to the named insurance company any information necessary to secure insurance payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. **Initial Here:** _____

I authorize and consent to any diagnostic and/or medical/dental treatment under the instruction of the attending physician and/or dentist for which my dependent or I have sought care. **Initial Here:** _____

I give Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) permission to verify the financial and insurance information provided by me to determine eligibility for Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) services. I understand it is my responsibility to keep Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) informed of any changes in my families income and insurance status. **Initial Here:** _____

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, processing of insurance claims, and/or for qualification for services to which I may be eligible. **Initial Here:** _____

Non-disclosure to Health Insurance:
I do not want my insurance company billed or notified of today's services. I understand that by doing this I am obligated to pay prior to services being rendered to myself or dependent. **Initial Here:** _____

Client Policy and Procedures: (Please initial)

I have received a copy of the "HIPAA Notice of Privacy Practices". **Initial Here:** _____

I have received a copy of the "Client's Rights and Responsibilities and Grievance Procedure". **Initial Here:** _____

I understand that there is a notification period of 24 hours prior to my appointment or my account will be charged $25.00 for any appointment(s) not kept. **Initial Here:** _____

I understand that there is a $20.00 service charge for any/all returned checks. **Initial Here:** _____

Signature **(Patient/Responsible Party/Legal Guardian)** _____ Date: _____

If Other signing, Please Print your Name here: _____

Reviewed By: (Ho'ola Staff Member) _____ Date _____