Ho`ola Lahui Hawai`i
Kaua`i Community Health Center

HO'OLA LAHUI HAWAI'I
KAUA'I COMMUNITY HEALTH CENTER
Dental Services
Client Registration Form
PLEASE ANSWER / COMPLETE ALL QUESTIONS

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 _____

Date of Birth _____ Age _____

Social Security # _____

Driver's License # _____

☐ Male ☐ Female ☐ Other

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) _____

Marital Status

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐ Other

☐ Annulled ☐ Interlocutory Decree ☐ Domestic Partner ☐ Unknown

Primary Language (SELECT ONE ONLY)

☐ English ☐ Other ☐ Unspecified

Specify Other _____

Do you need a translator? ☐ YES ☐ No

Worker Status (If applicable)

☐ Migrant Worker

☐ Seasonal Worker

Are you a Veteran?

☐ Yes ☐ No

RACE (SELECT ONE ONLY)			ETHNICITY (SELECT ONE ONLY)	
☐ American Indian or Alaska Native			☐ Chicano	☐ Cuban
☐ Asian Indian	☐ Black or African American		☐ Declined to Specify	
☐ Chinese	☐ Declined to Specify	☐ Filipino	☐ Hispanic or Latino	
☐ Guamanian or Chamorro	☐ Japanese		☐ Mexican	☐ Mexican American
☐ Korean	☐ Native Hawaiian		☐ Not Hispanic or Latino	
☐ Other Asian	☐ Other Pacific Islander		☐ Puerto Rican	
☐ Samoan	☐ Vietnamese	☐ White		

Homeless Status

☐ Not Homeless ☐ Transitional ☐ Street

☐ Doubling up ☐ Unknown ☐ Other

☐ Homeless Shelter

Housing Status

☐ Public ☐ Non-Public

Family Monthly Income:
(Please provide best estimate)

Monthly Income: _____

Family Size: _____

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

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

☐ I do not want to disclose Income Information

☐ 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: _____

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

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

Name: _____ Name: _____ Relationship: _____ Phone No.: _____

Relationship: _____ Phone No.: _____ Name of Medical Physician _____

PARENT INFO (IF MINOR)

MOTHER NAME _____ PHONE# _____ EMAIL _____

FATHER NAME _____ PHONE# _____ EMAIL _____

Student Status (Select One if applicable)

☐ 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 Coverage _____

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: _____

(Staff Member verified completion of Registration Form)
Reviewed By: (Print Name & Date) _____ DATE _____