KUHIO WALK-IN
MEDICAL CLINIC

Patient Registration

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Phone	Home	Work	Cell

Gender M ☐ F ☐	Email Address:
(Tourist only) Hotel	
(Immigration only) Place of birth	City, Village, or Town Country
How did you hear about us?	GOOGLE SEARCH ☐ YELP ☐ FRIEND ☐

Responsible Party / Primary Insurer (Guarantor) ☐ same as patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Phone	Home	Work	Cell

Emergency Contact

First Name	Last Name		
Address	City	State	Zip
Phone			Relationship to Patient

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the Kuhio Walk in Medical clinic to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize the Kuhio Walk in Medical clinic to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient