PEARL CITY MEDICAL ASSOCIATES. INC.

Signature of Authorization(s) on back side to be completed.

Date _____ Account # (for office use only) _____

PATIENT INFORMATION (please print)

Last Name _____ First Name, M.I. _____

Residence Address _____ City, St, Zip _____
(No P.O. Box Address)

Home Phone _____ Cell _____ Work Phone _____ Ext. _____

Sex _____ Birthdate _____

Employer _____
(If child, responsible party's employer)

Email Address _____

PERSON RESPONSIBLE FOR BILL

Last Name _____ First Name, M.I. _____

Mailing Addr. _____ City, St, Zip _____
(If other than above)

Phone _____ Work Phone _____ Ext. _____
(If other than above) (If other than above)

MEDICAL INSURANCE(S)

1st Insurance _____

ID# _____ Subscriber _____ Sex ____ DOB _____

2nd Insurance _____

ID# _____ Subscriber _____ Sex ____ DOB _____

3rd Insurance _____

ID# _____ Subscriber _____ Sex ____ DOB _____

SPOUSE INFORMATION IF MARRIED / IF UNDER AGE (18 years and younger)

Spouse (Husband) / Father - Name _____

Address _____ City, St, Zip _____
(If other than above) (If other than above)

Phone _____ Alternate Phone _____
(If other than above) (If other than above)

Spouse (Wife) / Mother - Name _____

Address _____ City, St, Zip _____
(If other than above) (If other than above)

Phone _____ Alternate Phone _____
(If other than above) (If other than above)

EMERGENCY CONTACTS (in case of an emergency, please call)

Name _____ Phone _____

Name _____ Phone _____

IMPORTANT NOTICE

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney and/or agency for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I hereby assign all medical and/or surgical benefits to which I am entitled to:
PEARL CITY MEDICAL ASSOCIATES, INC.

This assignment will remain in effect until evoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Appointment reminders will be sent to your cell phone number by text messages and/or sent to your email address. If you would like to opt out of either reminder method, please let us know in writing. Changes will be made within 5 business days. We are not responsible for any messaging fees issued by your phone carrier for these messages.

Signature _____ Date _____
(Patient or Responsible Party)*

*Signature of the patient, guardian and/or responsible party authorizing treatment, if patient is a minor.

Print name _____
(If other than patient, please print your name here.)

Please complete the following supplemental information. If you refuse, please circle the "Unknown/Refused" option.

Preferred
Language: _____ Refused

Ethnicity: **(circle one)**	Asian	Hispanic or Latino	Japanese	Non-Hispanic or Non-Latino	Unknown/Refused

Race: **(circle one)**	American Indian or Alaska Native	Asian	Black or African American	Japanese	Native Hawaiian or Other Pacific Islander
	White	Unknown/Refused			