

Adventist Health **REGISTRATION FORM**

Office Use Only:_ (CSR initial) *My initial signifies that the information on this

form has been uploaded into the EMR.

First Name:		Last Na	ame:		Suffix:
SSN:	Home Ph	one:	Ce	ll Phone:	
Middle Name:		Email Address:			
Date of Birth	/ /	Sex at Birth: 🗆 N	•	and receive specials, healt Marital Status: DMa	
Mailing Address:			City/Sta	ate/Zip Code:	
Address 2:					
	erred method of comm				
	 Drive By Insurance Employer Friend/F First Aid Station/Event 	amily 🛛 Hote	l 🛛 🗖 Interr	et 🛛 🖬 Instagram	Facebook
Preferred Pharma	cy City:		Preferred Pha	rmacy Zip Code:	
EMERGENCY CO	NTACT				
1. Name:		Relationship:		Phone Number:	
2. Name:		Relationship:		Phone Number:	
METHOD OF P	PAYMENT				
My method of pa	yment today will be at t	he responsibility of:	🖵 Self-Pay	Employer	
REASON FOR	VISIT TODAY				
Pre-employme	nt DPost-accident	Return-to-duty	Random	🗖 Job Change 🗖	Reasonable Cause
Other:					
EMPLOYER INF	ORMATION				
Company Name:					
Contact Person:		Phone	e Number:		
providers, or its e I understand t be conta responsibilitie	e information provided is co mployees responsible for any that any results pertaining to cted by URGENT CARE HAW/ s should my employer/future oyer/future employer. I under By signir	y errors or omissions that services paid by my empl All's billing department, ac e employer forfeit to pay fo	I may have made in o oyer/future employe cting on behalf of Urg or these services. An ay employee that I m	completing the information or may be requested. I und gent Care Hawaii regarding y payment issues are direct bust pay for these services	n on this form. Ierstand that I may g any financial tly between myself