BIG ISLAND Healthcare
ECARE Hawaii LLC

633 Ponahawai St., Ste 103 & 409 Kilauea Ave., Hilo, HI 96720
Phone: 808-885-DOCS (808-885-3627)
Fax: 808-969-3852

LAST NAME	SUFFIX	FIRST NAME	MI	PREVIOUS NAMES
PATIENT'S **MAILING** ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)				HOME PHONE
PATIENT'S **PHYSICAL** ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)				CELL PHONE
PREFERRED CONTACT ☐ CALL ☐TEXT ☐ EMAIL	EMAIL			WORK PHONE
DATE OF BIRTH	SEX ☐ M ☐F ☐OTHER	MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed		PREFFERED LAB
EMERGENCY CONTACT NAME		EMERGENCY CONTACT RELATION		PREFERRED PHARMACY
EMERGENCY CONTACT ADDRESS (if different from your address)				EMERGENCY CONTACT PHONE #
PREVIOUS PRIMARY CARE DOCTOR		LAST APPT		PHONE NUMBER

If patient is a MINOR, please complete the following:

PARENT/GUARDIAN'S NAME	RELATIONSHIP TO PT	MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
HOME PHONE	WORK PHONE	CELL PHONE	CHILD'S SCHOOL
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD		RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

☐ PRIVATE INSURANCE ☐ WORKERS' COMPENSATION ☐ NO-FAULT ☐ TPL

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F ☐DTR	BIRTHDATE
	EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F ☐DTR	BIRTHDATE
	EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE

OTHER INFORMATION

ARE YOU A SMOKER? ☐ Y ☐ N	ARE YOU HISPANIC? ☐ Y ☐ N	RACE ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Other

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:

Do you authorize the release of medical information about you to anyone such as your spouse, children, etc.?
☐ Y ☐ N **IF YES,** TO WHOM? RELATIONSHIP

I authorize and consent to diagnostic, medical, and surgical treatments rendered to me, my child or individual under my guardianship when provided under the instruction of my attending physician or nurse practitioner.

In case of a minor child or person under guardianship, this authorization will be valid even when I am not physically present during the treatment. I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being required but is given to provide authority and power to render care when the practicitioner, in the exercise of his/her best judgement, may deem advisable.

I understand that every effort will be made to use insurance coverage when applicable, but that I am ultimately responsible for all charges incurred at this office and whenever I am referred elsewhere for physician, laboratory or diagnostic services.

I authorize this office to disclose health information about me for treatment, payment, and operations. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me.

I authorize Big Island Healthcare, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, to Big Island Healthcare.

_____ _____ _____
Patient/Parent/Guardian Signature Relationship to Patient Date

Rev 07/23

FOR OFFICE USE ONLY

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UPDATED NEW