WAIMEA PRIMARY CARE
PATIENT REGISTRATION FORM

DOB:_____ **SSN:**_____

NAME:_____
(LAST) *(FIRST)* *(M.I)*

ADDRESS:_____|_____
(STREET) *(CITY)* *(STATE)* *(ZIP)*

CONTACT:_____|_____
(PHONE) *(EMAIL)*

ANATOMY: ☐ FEMALE ☐ MALE ☐ INTERSEX

RELATIONAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER:_____

(CHECK ALL THAT APPLY)

RACE: ☐ NATIVE HAWAIIAN ☐ PACIFIC ISLANDER ☐ NATIVE AMERICAN ☐ ALASKAN NATIVE
☐ ASIAN ☐ HISPANIC OR LATINO ☐ BLACK ☐ WHITE ☐ DECLINE/UNKNOWN

PRIMARY MEDICAL INSURANCE

_____
(INS COMPANY NAME)

_____
(INS NUMBER)

_____
(INS GROUP)

_____
*(POLICY HOLDER **NAME**)*

_____
*(POLICY HOLDER **DOB**)*

_____
*(POLICY HOLDER **SSN**)*

SECONDARY MEDICAL INSURANCE

_____
(INS COMPANY NAME)

_____
(INS NUMBER)

_____
(INS GROUP)

_____
*(POLICY HOLDER **NAME**)*

_____
*(POLICY HOLDER **DOB**)*

_____
*(POLICY HOLDER **SSN**)*

The medical relationship between Waimea Primary Care LLC (WPC) and the above named patient is deemed "At Will". At any time WPC may discontinue medical service or treatment by written notice to the above patient if it is deemed against the best interest of the clinic and it's staff or in the best medical interest of the patient. Examples of the Right to Discharge or Refuse Service include but are not limited to: Violence, Fraud, Drug Shopping, Medical Non-Compliance, and Extreme or Overly Complex Medical Issues requiring medical care going beyond clinic capacity. **Filling out this form does not guarantee acceptance as a WPC patient until reviewed and approved by the clinic physician.** By signing the signature line below the patient agrees to these terms set forth.

SIGNATURE:_____ **DATE:**_____/_____/_____