REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

PATIENT REGISTRATION FORM

TODAY'S DATE: / /

Patient's name (last, first middle) | **Nickname** | **Sex (M of F)** | **Date of Birth**

Preferred email **AND** **Preferred Cell phone number** **(for appointment reminders and contacting)**

BILLING ADDRESS

☐ Guardian ☐ Other

Attention to (name or industry) Relationship to patient

Address | City | State | Zip | Phone number

EMERGENCY CONTACT INFORMATION

Name of local friend or relative | Relationship to patient | Emergency contact # | Alternate contact #

INSURANCE INFORMATION: Is this patient covered by insurance? ☐ No, I will pay for visit ☐ Yes (please give us a copy of card)

1. PRIMARY INSURANCE: ☐ HMSA ☐ QUEST-HMSA ☐ Tricare ☐ Other:

Subscriber ID # (Social security number if TRICARE) | Coverage code | Group | Effective date

☐ Self ☐ Child ☐ M ☐ F

Subscriber name | Patient's relationship to subscriber | Sex | Date of Birth

2. SECONDARY INSURANCE: ☐ HMSA ☐ QUEST-HMSA ☐ Tricare ☐ Other:

Subscriber ID # (Social security number if TRICARE) | Coverage code | Group | Effective date

☐ Self ☐ Child ☐ M ☐ F

Subscriber name | Patient's relationship to subscriber | Sex | Date of Birth

I certify that the above information is accurate and current to the best of my knowledge. By providing my cell phone number and/or email address, I consent to Reis Pediatrics contacting me regarding my medical care via cell phone, text or email.
Credit Card Payment Authorization: ☐ Visa ☐ Mastercard ☐ Prefer not to provide (Required for hospital newborns and visitors)

Name on Credit Card | Card Number | Exp. Date | Security Code

Billing Address

By signing below, you are agreeing to and understand the above financial agreement and that you understand, as the patient and/or guarantor described above as being the patient, that you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

Print Name **Signature** **Date**