*On the Grounds of Castle Medical Center*
642 Ulukahiki Street, Suite 104 • Kailua, Hawaii 96734
Phone: 808.263.3233 • Fax: 808.263.3220

Name:______________________________ Date of Birth: _____ / ______ / ______

Address:______________________________ City / State / Zip:__________________

Phone:(     )______________________ Evening Phone: (     )____________________

Email:__________________________________________________________

Social Security #________________ Sex: M______ / F______

Martial Status: Single________ Married ________ Divorced_________ Widowed____________

Primary Care Physician:___________________________ Referred by :______________________

*Employer:*_______________________________Occupation:______________________________
Employer Address: ______________________________________________
City: __________________________ State: _______________________ Zip: _________________

*Primary Insurance*: ___________________________ ID#: ________________________________
Subscriber Name: _________________________ Date of Birth: ________/ _________/ _________
Relation to Patient: ____________________________

*Secondary Insurance*: __________________________ ID#: _______________________________
Subscriber Name: _________________________ Date of Birth: ________/ _________/ _________
Relation to Patient: ____________________________

*Emergency Contact*: _________________________ Relationship: __________________________
Address: _________________________ City: ______________ State: __________ Zip: ________
Home Phone: __________________________ Cellular Phone: _____________________________

**I authorize the release of confidential medical information to the following contact persons:**

Name_________________________________ Name___________________________________
Relationship___________________________ Relationship______________________________
Phone_________________________________ Phone___________________________________

Patient / Guardian Signature: ___________________________ Date: ______________________