JOHN D. BOYER, MD
PATRICK M. ELLISON, MD
The Queen's Physicians' Office Building II
1329 Lusitana Street, Suite 501
Honolulu, HI 96813
(O)808-521-1102 (F)808-521-1103

PATIENT REGISTRATION FORM

Appointment Date: _____/_____/_____
Month Day Year

Legal Name: _____Birthdate:_____ SS#:_____(for prescription medications)
Last First M.I.

Home Address: _____
Street # Street Name Apt City State Zip Code

Billing Address: _____

Home Phone: ( )_____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Prefer to be called (aka):_____ Military Rank/Rate: _____Active Duty or Retired Military?

Sex: Male or Female Marital Status: _____ Spouse's Name:_____

Patient's Occupation:_____ Patient's Employer:_____

Referring Physician: _____ Addr: _____ Phone: _____

Primary Care Physician: _____ Addr: _____ Phone:_____

Other Physician: _____ Addr: _____ Phone: _____

How did you hear about Dr. John Boyer? Other physician_____ Friend or relative____ Yellow pages____

PARENT OR RESPONSIBLE PARTY (If under 18 or different from Patient)

Name: _____ SS# _____
Last First M.I.

Address: _____
City State Zip

Home Phone: ( ) _____Work Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth _____/_____/_____ Sex: Male or Female Military Rank/Rate: _____ Active Duty or Retired?

INSURANCE INFORMATION: Please present insurance card and photo ID at time of check-in. All copayments are due at time of service.

Primary Insurance: _____ **Secondary Insurance**: _____

Name of Subscriber: _____ Name of Subscriber: _____

Relationship to Patient: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Insured's Membership #: _____ Insured's Membership #: _____

In case of Emergency, who should be notified? _____ Phone: _____

Do you have voicemail? Yes___ No___ If so, may we leave you voicemail messages from this office? Yes__ No__

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process claims insurance applications and prescriptions. I authorize payment of medical benefits to the physician.

_____ _____/_____/_____
Signature of Patient or Responsible Party Date