University of Hawai'i
University Health Services Mānoa
1710 East West Road | Honolulu, Hawai'i 96822
Phone (808) 956-8965
Patient Portal: https://healthservices.hawaii.edu

PATIENT REGISTRATION

PATIENT INFORMATION

Name: Last	First	Middle	UH ID #

Preferred First Name (if applicable)	Date of Birth (MM/DD/YY)	Sex	UH Email Address

Local Address	Apt.#	City	State	Zip code	Phone ( )
Permanent Address	Apt.#	City	State	Zip code	Phone ( )

Employer/UH Department

Employer Address	Phone ( )

Emergency Contact Name	Relationship	Phone (Home) ( )	Phone (Work/Cell) ( )

PRIMARY INSURANCE Company: Please attach copy of card (front and back)

Name of Insurance	Policy or ID#	Group #

Subscriber	Subscriber Date of Birth	Subscriber Sex	Plan #

Subscriber Address	Apt.#	City	State	Zip code

Subscriber Phone Number ( )	Effective Date	Expiration Date	Name of Primary Care Provider

Relationship to Subscriber: ☐ self ☐ child ☐ spouse ☐ other, specify: ____________________

SECONDARY INSURANCE Company: Please attach copy of card (front and back)

Name of Insurance	Policy or ID#	Group #

Subscriber	Subscriber Date of Birth	Subscriber Sex	Plan #

Subscriber Address	Apt.#	City	State	Zip code

Subscriber Phone Number ( )	Effective Date	Expiration Date	Name of Primary Care Provider

Relationship to Subscriber: ☐ self ☐ child ☐ spouse ☐ other, specify: ____________________

FINANCIAL RESPONSIBILITY: I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE UNIVERSITY OF HAWAI'I AT MĀNOA, UNIVERSITY HEALTH SERVICES AS INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier.

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Signature of Patient (Parental signature required if under 18) Date