MAUI HEALTH
Community hospitals affiliated with KAISER PERMANENTE®

PRE-REGISTRATION FORM
PATIENT INFORMATION

FAX TO: ADMISSIONS DEPT.
FAX # (808) 242-2338
OFFICE # (808) 242-2032

FROM: _____
FAX # _____
PHONE # _____

DATE OF SERVICE:

Last Name	First Name	MI	Marital Status ❑Single ❑Divorced ❑Married ❑Widow/er

Social Security Number	Birthdate	Sex ❑ Female ❑ Male	Veteran ❑ Yes ❑ No	Retired ❑ Yes ❑ No	Date Retired

Street Address	City	State	Zip Code	Home Phone

Mailing Address (if different from above)	City	State	Zip Code

Employer	Occupation	Employer Phone

Spouse's Name	Employer	Occupation

Emergency Contact	Contact's Address	Phone	Relationship

Insurance	Membership No.	Subscriber	Sub. Date of Birth	Relationship
1.				
2.				

Accident Date:_____ Type: ❑ Motor Vehicle ❑ Worker's Comp ❑ Other_____	Insurance Company Name Claim No.	Adjuster's Name Phone Number:

Admitting Dept.
Pre-Registration Form