ALOHA MALAMA HEALTH
HEALTH CARE BELONGS TO EVERYONE

Personal Information

Today's date: _____

Name (on insurance card):_____

Preferred Name: _____ Pronouns: He/Him, She/Her, they/Them, Other _____

Date of Birth: _____ Age: ____ State issued ID or SSN#: _____

Gender (on insurance) _____ Email address: _____

Mailing address: _____ City: _____State: ____

Zip code: _____ Primary Phone: ( )_____ (Cell, if different) _____

Marital Status: Single Married Divorced Widowed Other _____

Spouse/partner Name: _____

Employer: _____ Occupation: _____

Primary Insurance carrier & Member/subscriber ID #: _____

Secondary insurance carrier & Member/subscriber ID#: _____

Under who's name are these policies:_____

If other than yourself, please provide: name, relationship to you, phone number, legal gender, and date of birth of that person.

Name: _____ Date of Birth: _____ Relationship: _____

Legal Gender: _____ Phone number: _____

Preferred pharmacy: _____

In the Event of an Emergency, who should we contact?

Name: _____ Relationship to you: _____

Best contact number: _____

Who is your primary care provider (PCP)? _____