

AULIKE HEALTH PARTNERS LLC PATIENT REGISTRATION FORM

Today's Date: _____

Patient's Name (Last, First, Middle): _____

Nickname: _____

Sex, Gender Identity, Preferred Pronoun(s): _____

Date of Birth: _____

Preferred Email Address (for appointments and contacting): _____

Preferred Cell Phone Number (for appointments and contacting): _____

Billing Address:

Attention to (name) Relationship to patient (parent, guardian, self)

Address City State Zip

Emergency Contact Information:

Name of local friend or relative Relationship to patient Phone Number

Insurance Information: Is this patient covered by insurance? No, I will pay for visit
 Yes (please provide copy of insurance card)

1. Primary Insurance: HMSA QUEST-HMSA Tricare Other:____

Subscriber ID # (social security # if Tricare) Coverage code Group Effective date

 Self Child M F
Subscriber name Patient's relationship to subscriber Sex Date of Birth

2. Secondary Insurance: HMSA QUEST-HMSA Tricare Other:____

Subscriber ID # (social security # if Tricare) Coverage code Group Effective date

 Self Child M F
Subscriber name Patient's relationship to subscriber Sex Date of Birth

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I certify that the above information is accurate and current to the best of my knowledge. By providing my cell phone number and/or email address, I consent to Aulike Health Partners LLC contacting me regarding my medical care via cell phone, text or email.

Print Name

Signature

Date