

AULIKE HEALTH PARTNERS LLC PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name (Last, First, Middle). Please all children if applicable: _____

Nickname(s): _____

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

Date(s) of Birth: _____

Preferred Email Address (for appointments and contacting): _____

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

Parent or Legal Guardian Information:

Mother/Guardian Name _____ Date of Birth _____

Address (City, State, Zip) _____

Phone Number _____

Father/Guardian Name _____ Date of Birth _____

Address (if different than above) _____

Phone Number _____

Billing Address (if different than above):

Attention to (name) _____ Relationship to patient (guardian, other) _____

Address (City, State, Zip) _____

Emergency Contact Information:

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 _____

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

AULIKE HEALTH PARTNERS LLC PATIENT REGISTRATION FORM

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

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