Primary Care Clinic of Hawaii

PATIENT INFORMATION SHEET

Name: JHON M ASAY
First Name Middle Initial Last Name

Address: 2704 KAMANAIKI ST
HONOLULU, HI 96819

Home Phone: (_____)_____ Sex: MALE Birthdate: 05/21/1987

Mobile Phone: (661)944-7633 Marital Status: ( ) Single ( ) Married Other ( )

Social Security No: 621-98-7907 Referred By: OHANA HEALTH PLAN

Employer: SELF EMPLOYED Phone: (_____)_____

Address: _____

Job Title: JUNI-STORE.COM - OWNER

Emergency Contact: JESSICA AGUIRRE Phone: (661)236-2810

Relationship: FIANCE Occupation: _____

Employer: _____ Phone: (____)_____

Responsible Party: SELF Phone: (661)944-7633

Address: 2704 KAMANAIKI ST, HONOLULU, HI 96819

Primary Insurance: OHANA HEALTH PLAN Policy No: 35301766

Subscriber: JHON ASAY Relationship SELF Birth date: 05/21/1987

Other Insurance: _____ Policy No: _____

Subscriber: _____ Relationship _____ Birth date: _____

Insurance Authorization - Please Read and Sign

I hereby authorize my doctor to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible not covered by insurance.

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care financing administration and its agents any information needed to determine these benefirst or the benefits payable for related service.

Signature: _____ Date: 9/27/2022