Ke Ola Mamo
A Native Hawaiian Health Care System
1505 Dillingham Blvd. Room 205
Honolulu HI 96817

Client Name ____________________ Date of Birth __________
Account # ______________________________

Sliding Fee Discount

If you are uninsured, you may apply for a discount according to your family size and income amounts. If you qualify, you would pay a percentage of any billable charges. If you are interested in this discount, please let us know.

Please complete entire form in **black** ink ONLY

CLIENT INFORMATION

Date: ______________

Client Name: ____________ (Last) ____________ (First) ______ (M.I.)

Other Name: ____________ (Last) ____________ (First) ______ (M.I.)

Mailing Address: ______________ **City:** __________ **Zip Code:** ______

Residence Address: ______________ **City:** __________ **Zip Code:** ______

Primary #: __________
- ☐ check if okay to leave message
- ☐ check if okay to identify ourselves
- ☐ check if primary contact #

Work #: __________
- ☐ check if okay to leave message
- ☐ check if okay to identify ourselves
- ☐ check if primary contact #

Cell #: __________
- ☐ check if okay to leave message
- ☐ check if okay to identify ourselves
- ☐ check if primary contact #

SSN: ____ - ____ - ____ ☐ Declined **Date of Birth:** __________ **Gender:** ☐ Male ☐ Female ☐ TG-Male* ☐ TG-Female**

*Female to Male **Male to Female

Race:

☐ Native Hawaiian ☐ more than 50% ☐ less than 50% ☐ White ☐ Pacific Islander

☐ American Indian Tribe __________ ☐ Asian ☐ Black/African American

☐ Alaska Native Tribe __________ ☐ Unknown/Refused ☐ Other __________

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Not Latino ☐ Unknown/Refused

Primary Language: ☐ English ☐ Hawaiian ☐ Other (please list): __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Widower ☐ Legally Separated ☐ Partner

RESPONSIBLE PARTY INFORMATION

Relationship to Client ☐ Self* (If Self, please skip to Employer) ☐ Spouse ☐ Parent ☐ Guardian

Responsible Party Name ____________ (Last) ____________ (First) ______ (M.I.)

Mailing Address: ______________ **City:** __________ **Zip Code:** ______

Residence Address: ______________ **City:** __________ **Zip Code:** ______

Home #: __________ **Work #:** __________ **Cell #:** __________

SSN: ____ - ____ / ____ ☐ Declined **Date of Birth:** __________ **Gender:** ☐ Male ☐ Female ☐ TG-Male* ☐ TG-Female**

*Female to Male **Male to Female

Employer*: ______________ **Phone #:** __________

Address: ______________ **City:** __________ **Zip Code:** ______

Family Size: ______ **Income** $ ________ ☐ Monthly ☐ Annual

Income Source: ☐ None ☐ Self ☐ Spouse ☐ Partner ☐ Family ☐ DSSH – TANF ☐ DSSH – Food ☐ Unemployment ☐ Soc. Security Benefits ☐ SSI ☐ SSDI ☐ Other: __________

Employed: ☐ Part time ☐ Full time ☐ Student ☐ Retired ☐ Self-employed ☐ Unemployed ☐ Other: __________

Living Arrangement: ☐ Own Home ☐ Rent Home ☐ Living with family ☐ Homeless ☐ Other __________

Homeless: ☐ Not homeless ☐ Homeless shelter ☐ On the Street ☐ Doubling Up ☐ Transitional ☐ Hidden Homeless ☐ Yes, From: ____ / ____ To: ____ / ____ ☐ Yes, but unknown

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INSURANCE INFORMATION

☐ None ☐ MedQuest Status ☐ Pending ☐ Denied ☐ Refused to apply ☐ Sliding Fee Schedule ☐ Completed SFS paperwork

☐ Yes ☐ Medical ☐ Prescription ☐ Dental ☐ Copy of insurance card(s) made

Insurance #1: ______________________ **ID#** ______________________

Insured Name: ______________ Last ______________ First ______ M.I.

Address: ______________________ **City:** ______________ **Zip Code:** ________

SSN: _____ - _____ - _____ ☐ Declined **Date of Birth:** ______________

(If applicable list any additional or supplementary insurance)

☐ Not applicable ☐ Medical ☐ Prescription ☐ Dental ☐ Both ☐ Copy of insurance card(s) made

Insurance #2: ______________________ **ID#** ______________________

Insured Name: ______________ Last ______________ First ______ M.I.

Address: ______________________ **City:** ______________ **Zip Code:** ________

SSN: _____ - _____ - _____ ☐ Declined **Date of Birth:** ______________

PROVIDER INFORMATION

Doctor Name: ______________________ Phone #: ______________

Doctor Address: ______________________ Fax #: ______________

Dentist Name: ______________________ Phone #: ______________

Dentist Address: ______________________ Fax #: ______________

ADDITIONAL INFORMATION

Emergency Contact Person: **Relationship:** **Emergency Contact #:**
(If possible someone outside your home we may talk to about your health)
______________________ ______________ ______________

Who may we talk to about your health? **Relationship:** **Contact #:** **Good Until** (date)
______________________ ______________ ______________ ______________

Veteran Status:
Are you now serving in the U.S. Military/Coast Guard? ☐ Yes ☐No ☐ Not Applicable
Have you ever served in the active U.S. Military/Coast Guard? ☐ Yes ☐ No ☐ Not Applicable

Referred By: ☐ Self ☐ Family ☐ Friend ☐Doctor ☐ Agency: ______________
☐ Not Applicable ☐ Other: ______________

Health Care Utilization:
What types of health care do you use when you are sick/ill? ☐ Doctor ☐ Medical clinic ☐ Lomilomi
☐ Alternative Therapy (e.g., aroma, herbal, etc) ☐ None ☐ Other ______________