PATIENT INFORMATION FORM

Please let us know if someone referred you to our office!

Referred by: _____

BRYAN MIH, MD, MPH, FAAP
1319 Punahou St, #1020, Honolulu, HI 96826

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS	CITY, STATE AND ZIP CODE	

SOCIAL SECURITY NO.	DATE OF BIRTH	☐ Male ☐ Female ☐ Nonbinary	ETHNICITY

PARENT OR LEGAL GUARDIAN INFORMATION

NAME (LAST, FIRST, MI) ☐ Mother ☐ Father ☐ Legal guardian		NAME (LAST, FIRST, MI) ☐ Mother ☐ Father ☐ Legal guardian	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH
PHONE #1 ☐ Cell ☐ Home ☐ Work	PHONE #2 ☐ Cell ☐ Home ☐ Work	PHONE #1 ☐ Cell ☐ Home ☐ Work	PHONE #2 ☐ Cell ☐ Home ☐ Work
EMAIL		EMAIL	
ADDRESS (if different from patient) ☐ Same as above		ADDRESS (if different from patient) ☐ Same as above	
OCCUPATION	EMPLOYER	OCCUPATION	EMPLOYER

PRIMARY INSURANCE

SECONDARY INSURANCE (if applicable)

SUBSCRIBER NAME (LAST, FIRST, MI)	SUBSCRIBER NAME (LAST, FIRST, MI)
INSURANCE NAME	INSURANCE NAME
MEMBER NUMBER	MEMBER NUMBER

EMERGENCY CONTACTS: two individuals other than parents/legal guardians listed above

NAME	RELATION TO PATIENT	PHONE #1 ☐ Cell ☐ Home ☐ Work	PHONE #2 ☐ Cell ☐ Home ☐ Work
NAME	RELATION TO PATIENT	PHONE #1 ☐ Cell ☐ Home ☐ Work	PHONE #2 ☐ Cell ☐ Home ☐ Work

☐ I hereby acknowledge that I reviewed a copy of Bryan Mih, MD's **Office Rules and Regulations**. I have read and understand the Office Rules and Regulations, and agree to abide by the terms set forth within the Office Rules and Regulations. I further acknowledge that a copy of the Office Rules and Regulations is available on request.

☐ I have read, understand, and agree to abide by Bryan Mih, MD's **Notice of Privacy Practices**. I further acknowledge that a copy of the Notice of Privacy Practices is available on request.

☐ I hereby authorize Dr. Bryan Mih to release my medical information, including copies of medical records, to my insurance carriers concerning my illness and treatment, and assign all my payments for medical services to my doctor. **I understand I am responsible for any amount not covered by my insurance.**

SIGNATURE _____ RELATION TO PATIENT _____ DATE _____

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