KAISER PERMANENTE® **HAWAII REGION**

Personal History Sheet

❑ Health Plan ❑ Mainland Health Plan: Region________________

❑ Non Plan Mainland Health Plan MR #: ________________

MR #:

Name:

Sex / BD:

INSTRUCTIONS TO PATIENT OR PATIENT REPRESENTATIVE

1. In order to provide you with the best possible care, please complete each section thoroughly and truthfully with **BLACK INK**. Please provide your picture I.D. to Kaiser Permanente Staff so that we can correctly identify you.
2. If you are completing this form for the patient, please write your name, your relationship to the patient, and your phone number on the lines below so that we may contact you if we have questions.

______________________ Name of person completing this form for the patient ______________ Relationship to patient ______________ Phone #

Patient Information

______________ Legal Last Name ______________ Legal First Name ______________ Full Middle Name ______ Suffix (Jr, Sr, etc.)

______________ Former Last Name ______________ Former First Name ______________ Maiden Name ______________ Nickname

Birth date: _____| _____| _______ (MM DD YYYY) **Sex:** ❑ **Male** ❑ **Female** **Social Security #:** ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Birth place: ______________ City ______________ State ______________ Country **Religion:** ______________

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Domestic Partner ❑ Other: ______________

Permanent Mailing Address:

______________ Street / Apt / or PO box ______ City ______ State ______ Zip code

Home: ( ) ______________ ❑ TTY

Work: ( ) ______________

Cell: ( ) ______________

Temporary Address: Begin Date: _____| _____| _______ End Date: _____| _____| _______

______________ Street / Apt / or PO box ______ City ______ State ______ Zip code

Temp: Phone: ( ) ______________

circle type of temp ph#: cell / home / work

Number, in order of priority, (1, 2 & 3) the Race(s) you most identify with:

___American Indian / Alaska Native
___Asian
___Black / African American
___Caucasian
___Hispanic / Latino
___Native Hawaiian / Other Pacific Islander
___Other ___Unknown ___Decline to State

What is your Ethnicity, your cultural heritage? (number in order of priority: 1, 2 & 3) **(for example: Chinese, Filipino, German, Japanese, and so on)**

___Chinese
___English
___Filipino
___German
___Guamanian / Chamorro
___Hawaiian / Native Hawaiian
___Japanese
___Korean
___Mexican
___Okinawan
___Part Hawaiian
___Portuguese
___Puerto Rican
___Samoan
___Vietnamese
___Other ______________
___Other ______________
___Other ______________
___Unknown
___Decline to state

What Language do you feel most comfortable speaking? ______________

What Language do you feel most comfortable writing? ______________ **Do you need an Interpreter?** ❑ **Yes** ❑ **No**

(Race, ethnicity, and language are requested for diversity research, Dept of Health requirements, and per the 2009 Health Care Reform Act)

Emergency Contact 1: ______________ ______________ Relationship Ph #. ( ) ______________ circle type: cell / home / work

Emergency Contact 2: ______________ ______________ Relationship Ph #. ( ) ______________ circle type: cell / home / work

❑ **Spouse Name** ______________ Last Name, First Name ❑ **Partner Name** ______________ Last Name, First Name

If form completed for a minor, please provide: ______________ Mother's Full Name ______________ Father's Full Name

I have read and understand the above questions and declare that my answers are accurate to the best of my knowledge.

Signature: X ______________ Patient • Parent • Legal Representative ______________ Relationship Date: ____| ____| ______ (MM DD YYYY)

FOR KAISER USE ONLY

1. Verify and make a copy of the valid photo I.D. and/or legal documentation.
2. Specify type of photo I.D. reviewed: ❑ Driver's license ❑ State I.D. ❑ Other:__________
3. Print Staff Name: ______________ Dept: ______________ Ph #: __________
4. Attach copy of photo I.D. and send <u>to Patient ID / Dole</u>

Kauai PCP Stamp or print with black ink

______________ Physician Name

______ Provider # ______________ Department

Fax completed document to: (808) 432-5050

Original:

Send to: Patient ID

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