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. Please provide your picture I.D. to Kaiser Permanente Staff so that we can correctly identify you.
2. Print all information with black ink.
3. 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: ( ) ________

Temp: Phone: ( ) ________

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

Temporary Address: Begin Date: ____ | ____ | ______ End Date: ____ | ____ | ______

Street / Apt / or PO box ________ City ________ State ________ Zip code ________

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	___ Korean	___ Vietnamese
___ English	___ Mexican	___ Other ________
___ Filipino	___ Okinawan	___ Other ________
___ German	___ Part Hawaiian	___ Other ________
___ Guamanian / Chamorro	___ Portuguese	___ Unknown
___ Hawaiian / Native Hawaiian	___ Puerto Rican	___ Decline to state
___ Japanese	___ Samoan	

What Language do you feel most comfortable speaking? ________ **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 **to Patient ID / Dole**

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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