Stellar Women's Health Specialists
Celeste Adrian, MD, FACOG
30 N. Church Street, Suite 300
Wailuku, HI 96793
Telephone (808) 242-9787
Fax (888) 972-5617

Patient Information

Name: Last First M.I	Date of Birth	Marital Status	Social Security #
Street Address: City Zip Code	Cell Phone		Home Phone
Mailing Address: City Zip Code	Employer		Work Phone
Email:	Pharmacy:		Preferred Language:
Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Refuse to Answer			
Race: ____Native Hawaiian or Other Pacific Islander ____Asian ____White ____Black or African American ____American Indian or Alaska Native ____Refuse to Answer			

Spouse Information

Name: Last First M.I	Date of Birth	Telephone

Parents Information (complete if patient is a minor)

Mother's Name: Last First M.I	Date of Birth	Telephone
Father's Name: Last First M.I	Date of Birth	Telephone

Emergency Contact

Name	Telephone	Relationship to Patient

Primary Care Physician

Name	Telephone

Medical Insurance

Primary Insurance	Subscriber/ID #	Group #
Subscriber Name	Date of Birth	Coverage Code
Secondary Insurance	Subscriber/ID #	Group #
Subscriber Name	Date of Birth	Coverage Code

I authorize the release to the above insurance carriers or the Health Care Financing Administration of any information relating to all claims for benefits submitted on behalf of myself and/or dependants. This will include any information on sexually transmitted diseases and HIV. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services without obtaining my signature on each and every claim for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I also authorize my insurance company or Medicare to pay and hereby assign directly to Celeste Adrian MD LLC all benefits, if any, otherwise payable to me for services.

All co/payments are due at time of service. A returned check fee of $30 will be applied to your account for each check returned.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information above. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Parent Signature (if minor) Date

I acknowledge that I have received a copy of Celeste Adrian MD LLC Notice of Privacy Practices with the effective date of September 6, 2013.

______________________________ ______________________________
Patient Signature Date