Ministry of Health
P.O. Box 6027 Koror, Republic of Palau 96940
Phone: (680) 488-2552/3 Fax: (680) 488-1211
E-mail: mohrop@palauhealth.org Website: www.palauhealth.org

Patient Information/Registration Form

To be completed by patients 18yrs. & Older. Parents are responsible to complete forms for underage patients.

Hospital Number: ____________ Today'sDate: ____________

Legal Last Name: ____________ Legal First Name: ____________ M.I. ______

Other Name Used: ____________

DOB: ____________ Birth Place: ____________ Gender: ☐Male ☐Female

Ethnicity ____________ Citizenship: ____________ Religion: ____________

Sexual Orientation: ____________ Sexual Identity: ____________

(i.e. Lesbian, Homosexual, Bi-sexual, straight, Asexual) *(Whom you are romantically/sexually attracted to)*

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow Tourist: ☐Yes ☐No

Social Security #: ____________ Passport #: ____________

Mailing Address: ____________ Contact #: (H) ____________

Hamlet: ____________ (W) ____________

(C) ____________

Permanent Mailing Address: ____________

(For Non-Local Residence) ____________

City State Zip Code

Occupation: ____________ Monthly Income: $____________________________

Employer's Name: ____________ Name of Business: ____________

Insurance Company: ____________ Policy #: ____________

Responsible payer: ____________ Hosp.#: ____________

Emergency Contact: ____________ Contact #: ____________ **Relationship:** ____________

Dependents: List Names, SS#, Hospital #, Relationship *(Use other side if necessary)*

	Name	SS#:	Hosp. #	Relationship:
1				
2				
3				
4				
5				
6				

Provide Biological Information

Father's Full Name: Mother's Maiden Full Name:

Foreign workers Only:

Work Permit #: Expiration Date:

Certification: By my Signature, I certify that the above information is complete and True.

____________ ____________

Signature Date