# BRAUN URGENT CARE Kailua

## PATIENT REGISTRATION

**Name** _____ **Age** _____
LAST FIRST M.I.

**SSN/HDL/HID** _____ **Date of Birth** _____/_____/_____ **Sex** _____ **Marital Status** _____

**Home Address:** _____

_____

**Phone: Cell** _____ **Work** _____

**Primary Care Doctor:** _____ **Phone:** _____

**Employer:** _____ **Position:** _____

**E-MAIL:** _____

**TRICARE:** ☐ Standard ☐ Prime **SPONSOR:** _____

**Sponsor SS #** _____ **DOB** _____