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## PATIENT HISTORY

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Birth Gender: M F Marital Status: S M D W

**Home Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Business Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Patient's employer: \_\_\_\_\_

Spouse's name (if minor, parent's name): \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Primary language: \_\_\_\_\_ Nationality: \_\_\_\_\_

Do you speak fluent English?: Yes  No

Person responsible for payment: \_\_\_\_\_

Address while in Hawaii: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In case of emergency, person to notify: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical Insurance Information

Insured's Name \_\_\_\_\_ Carrier \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

### How did you happen to come to Dr. Ferguson?

Physician referral ó Name: \_\_\_\_\_

Friend referral ó Name: \_\_\_\_\_

Other referral ó Name: \_\_\_\_\_

Advertisement ó Television Radio Which: \_\_\_\_\_

Internet- Yelp Google Message Boards Other: \_\_\_\_\_

Yellow Pages \_\_\_\_\_

Other: \_\_\_\_\_