HAWAII PACIFIC NEUROSCIENCE

Thank you for choosing our office! In order to serve you properly, we will need the following information.
Please print. All information will be confidential.
PHYSICAL ADDRESS REQUIRED FOR PERSCRIPTION AND BILLING PURPOSES

## Patient Information

Name _____ ☐ Male ☐ Female Birthdate ____/____/_____
LAST FIRST MI

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Home Phone (_____)_____-_____ Alternate Phone (_____)_____-_____ SSN _____

Email Address _____ Preferred Pharmacy _____

Primary Physician _____ Referring Physician _____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Employer _____ Work Phone (_____)_____-_____

Business Address _____ City_____ State _____ Zip code _____

Emergency Contact _____ Relationship _____ Phone (_____)_____-_____

Power of Attorney? ☐ Yes ☐ No If yes, who? _____ **Please provide a copy of the POA

## Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Birthdate _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Home Phone (_____)_____-_____ Alternate Phone (_____)_____-_____ SSN _____

Responsible Party's Employer _____ Work Phone (_____)_____-_____

Business Address _____ City_____ State _____ Zip code _____

## Primary Insurance

Insurance Company _____ Subscriber No. _____ Group No. _____

Name of Insured_____ Relationship to patient _____
LAST FIRST MI

Birthdate _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Home Phone (_____)_____-_____ Alternate Phone (_____)_____-_____ SSN _____

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Do you have additional insurance? ☐ Yes ☐ No If yes, complete the following:

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## Secondary Insurance

Insurance Company _____ Subscriber No. _____ Group No. _____

Name of Insured_____ Relationship to patient _____
LAST FIRST MI

Birthdate _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Home Phone (_____)_____-_____ Alternate Phone (_____)_____-_____ SSN _____

Race (check one of the following) :

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Black or African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Prefer not to say

Ethnicity (check one of the following):

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Prefer not to say

Language (check one of the following):

- ☐ English
- ☐ Other: _____

Translator needed? ☐ Yes ☐ No

I certify that the information provided is true and correct to the best of my knowledge and belief and I understand and agree that I have a continuing obligation to advise Hawaii Pacific Neuroscience, LLC if there is a change in circumstances.

| _____ | _____ | _____ |
|---|---|---|
| Patient or Guarantor (Print Name) | Patient or Guarantor Signature | Date |