HAWAII PACIFIC NEUROSCIENCE

Thank you for choosing our office! In order to serve you properly, we will need the following information.
Please print clearly. All information will be confidential.
FIELDS MARKED * REQUIRED FOR PRESCRIPTION AND BILLING PURPOSES

Patient Information

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

Mailing Address* _____ City_____ State _____ Zip code _____

Street Address* _____ City_____ State _____ Zip code _____

Primary Phone* (_____)_____-_____ Preferred method of contact*: ☐ Call ☐ Text ☐ No Preference

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 (_____)_____-_____

Approved Contact _____ Relationship _____ Phone (_____) _____-_____

*By approving this contact, you are allowing this person access to all your PHI information.

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

Responsible Party

Name of Responsible Party* _____ Relationship to patient* _____

Birthdate _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Primary Phone* (_____)_____-_____ Alternate Phone (_____)_____-_____ SSN _____

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

Primary Insurance

Insurance Company* _____ Subscriber ID*_____ Group No. _____

Name of Insured*_____ Relationship to patient* _____
LAST FIRST MI

Insured's Birthdate* _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Primary Phone* (____)_____-_____ Alternate Phone (____)_____-_____ SSN* _____

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

Secondary Insurance

Insurance Company* _____ Subscriber ID* _____ Group No. _____

Name of Insured* _____ Relationship to patient* _____
LAST FIRST MI

Insured's Birthdate* _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Primary Phone* (____)_____-_____ Alternate Phone (____)_____-_____ SSN* _____

Race (check one of the following) :

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ 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