REGISTRATION FORM

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PATIENT INFORMATION

Name _____
Last First Middle

Address _____

Sex ☐ M ☐ F Other ☐ Age _____ Birthdate _____ Social Security Number _____

Cell Phone Number _____ OK to leave a message? (Y/N) OK to text for appointment coordination? (Y/N)

Home Phone Number _____OK to leave a message? (Y/N) Work Phone Number _____OK to leave a message? (Y/N)

Preferred Mode of Contact: ☐ Home ☐ Cell ☐ Work

Emergency Contact & Relationship: _____ Phone Number: _____

Referred by_____

INSURANCE COVERAGE

Person Responsible for Account _____
Last First Middle

Relation to Patient _____Birthdate _____ Social Security Number _____

Address (if different from patient's) _____ Phone _____

Person Responsible Employed by _____ Address _____

Insurance Company _____ Subscriber # _____ Group # _____

Subscriber Name _____ Additional Insurance? (Y/N) If yes, Name and #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
(Name of insurance)

- I authorize use of this form on all of my insurance submissions.
- I authorize the release of information to my insurance company(s) and medical biller if used (electronic billing).
- I understand that I am responsible for the full amount of my bill for services provided.
- I authorize direct payment to my service provider.
- I hereby permit a copy of this to be used in place of an original.
- It is the patient's responsibility to pay any deductible amount, co-pay, co-insurance amount, or balance not paid by your insurance on the day services are provided.
- There will be a $25 service charge on all returned checks.
- In the event that the account goes to collection, there will be a 20% collection fee added to the balance due.
- This provider cannot provide phone services when patient is out of the state of Hawai`i, due to interstate practice guidelines.

Signature_____ Date_____

Signature of Parent/Legal Guardian (if minor)_____ Date_____