



**HEARING DOCTORS  
OF HAWAII, LLC**

**PATIENT REGISTRATION**

**Honolulu**  
2226 Liliha Street  
Suite 410  
Honolulu, HI 96817  
Phone: (808)524-1432

**Hilo**  
101 Aupuni Street  
Room 113  
Hilo, HI 96720  
Fax: (808)524-1338

Account #:

Patient's Name \_\_\_\_\_  
Last Name First Name Middle Initial

Sex: M \_\_\_ F \_\_\_ Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**FAMILY INFORMATION (DEPENDENTS ONLY)**

Parent/Guardian Responsible for bill: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Primary Insurance

Secondary Insurance

Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_ Subscriber's Birthdate: \_\_\_\_\_

Member Number: \_\_\_\_\_ Member Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I certify to the accuracy of the above information. I authorize Hearing Doctors of Hawaii, LLC to treat the above named patient as deemed necessary. I also authorize the release of any information necessary to process claims or to collect amounts due.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Please read and acknowledge by signing below:**

- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy however I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I understand that if I am unable to make my appointment I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule or be worked into the day. If I do not show for my appointment and do not call to office to cancel my appointment in advance, I will be considered a no show and may be charged a \$25 no show fee.
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying \$25 fee in addition to re-issuing payment for a returned check.
- Consent for Treatment: I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provider has deemed necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- Consent of Treatment of Minors: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated.
- I hereby acknowledge that I received or have access to Hearing Doctors of Hawaii, LLC Notice of Privacy Practices.

---

Print name

---

Signature

---

Relationship to Patient

---

Date