PATIENT REGISTRATION

Honolulu
1229 Young Street
Honolulu, HI 96814
Phone: (808)524-1432

Hilo
101 Aupuni Street #112
Hilo, HI 96720
Fax: (808)524-1338

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: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

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. I

Patient/Parent/Guardian Signature: _____ Date: _____

HEARING DOCTORS OF HAWAI`I , LLC

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 understand that I am responsible for any amount not covered by my insurance.
- All patients are expected to pay their portion of the bill or make arrangements for alternative payment within 30 days of their first statement.
- 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

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hearingdoctorshawaii.com

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