HAWAII
ANXIETY AND TRAUMA
CARE

REGISTRATION FORM

PATIENT INFORMATION

Name _____
Last First Middle

Address _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

E-mail Address _____ OK to send bills/statements by email? ☐ Y ☐ N

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

Occupation _____ Employer _____

Your Regular Doctor's Name _____ Referred by _____

Emergency Contact & Relationship _____ Phone Number _____

INSURANCE COVERAGE

Person Responsible for Account _____
Last First Middle

Relation to Patient _____ Birthdate _____

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

Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Primary Insurance _____ Policy (Or Subscriber) # _____ Group # _____

Subscriber Name _____ Subscriber Birthdate _____ Co-payment _____

Secondary Insurance (if any) _____ Policy (Or Subscriber) # _____ Group # _____

Subscriber Name _____ Subscriber Birthdate _____ Co-payment _____

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.

Patient/Guardian Signature _____ Date _____