Registration Form

Patient’s Name:__________________________________ Date of Birth:____________
Social Security Number:__________________________ Gender (circle one): M F
Address:____
City:_______________________ State:____________ Zipcode:__________________
Home Phone:________________________ Cell Phone:_________________________
Occupation:_________________________ Employer:_________________________
Address:______________________________________ Work Phone:______________
Email:____
Marital Status (circle one): Single Married Separated Divorced
Spouse’s Name:____
Children in Family (names, ages, occupation):__________________________________
____
Primary Care Physician (PCP):______________________ Phone:__________________
Current Medications:____
Reason for visit:____
Referred by:__________________________ May I thank this person? Yes___ No___

Emergency Contact Name:___________________________ Relationship:___________
Address:____ Phone:_________________

Insurance Information (please bring card & ID to visit)
Medical Insurance Company:____
Membership Number:_______________________ Group Number:________________
Subscriber’s Full Name:_______________________ DOB Subscriber:____________
Relationship to Subscriber:____

Secondary Insurance Company:____
Membership Number:_______________________ Group Number:________________
Subscriber’s Full Name:_______________________ DOB Subscriber:____________
Relationship to Subscriber:____

Complete box if client is minor:

Parent/Legal Guardian Name:____
Address:____ Phone:_________________
Occupation:_________________________ Employer:_________________________

Work Address:__________________________________ Work Phone:_____________
Minor’s School:_________________________________ Grade:__________________

I hereby authorize Ho’okō LLC to furnish information to insurance carriers, government agencies and/or third party billing entity concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

Signature:___________________________________ Date:____________________