

I Ola Lāhui, Inc.
677 Ala Moana Boulevard, Suite 904
Honolulu, Hawai'i 96813
Phone: (808) 525-6255
Fax: (808) 525-6256

NEW PATIENT INFORMATION SHEET

Patient Information

Name: _____ Social Security: ____-____-____

Age: _____ Date of Birth: _____ Gender: Male _____ Female _____

Marital Status: Single Married Separated Divorced Widowed

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employment Status: Full Time Part Time Retired Not Employed

Occupation: _____ Employer: _____

Are you a Veteran of the United States military? Yes No

Referral Source: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

• Primary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber #: _____ Group #: _____

• Secondary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above and assign directly to I Ola Lāhui all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by the insurance company. I hereby authorize I Ola Lāhui to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I will notify I Ola Lāhui of any changes in the above information.

Responsible Party Signature

**Relationship to Patient
(if not signed by patient)**

Date