

DR. JAMES H. HATTAWAY, D.C.

MAUI FAMILY CHIROPRACTIC

95 Lono Avenue, Suite 203, Kahului, HI 96732
Office (808) 871-6218 * Fax 871-6253

CONFIDENTIAL PATIENT INFORMATION

(Please PRINT Clearly)

Date: _____

Name: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Sex: **M F** Marital Status: **S M W D**
Cell Phone: _____ Home Phone: _____ E-Mail: _____
Spouse's Name & Age: _____
Children Names and ages: _____

Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip Code: _____
Work Phone: _____ Direct Line: _____ Fax Phone: _____

How were you referred to our office? _____
Have you ever been to a chiropractor before? _____ If so, when? _____

List your chief discomfort(s), sustained from this motor vehicle accident, in order of severity:
1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

List other doctor(s) consulted for these conditions:
1. _____ Address _____ Phone: _____
2. _____ Address _____ Phone: _____

List medication(s) you are taking:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Date of Motor Vehicle Accident: _____
Who is your motor vehicle insurance carrier? _____
Has this accident been reported to your motor vehicle insurance company? Yes _____ No _____
If yes, please provide your Claim#: _____ Adjuster: _____

Females: Are you pregnant? Yes _____ No _____ Not Sure _____
Please notify the doctor if you *are* pregnant or *possibly* pregnant.

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Dr. James Hattaway's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to James Hattaway D.C., Inc. will be credited to my account on receipt. However, I clearly understand and agree that all service rendered me is charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorneys and legal action becomes necessary to collect this account. I authorize James H. Hattaway D.C. to obtain a credit report, if necessary.

Patient's Signature

Date

Patient/Guardian's Signature for Authorized Care:

Date

Authorized Care Signature

Date

In Case of Emergency notify: _____

Name of nearest relative

Relationship

Address, City, State

Phone Number