

JAMES H. HATTAWAY, D.C., INC

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? _____

How serious are you in correcting your subluxations?

Temporary Relief 0 1 2 3 4 5 Max Removal of Nerve Interference

How committed are you to provide wellness for your entire family?

None 0 1 2 3 4 5 Very

List your chief discomfort(s) 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. _____

Females: Are you pregnant? Yes _____ No _____ Not Sure _____

Please notify the doctor if you *are* pregnant or *possibly* pregnant.

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1. **ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED.**
2. WE ACCEPT MOST INSURANCE THAT INCLUDES CHIROPRACTIC COVERAGE. HOWEVER, YOU WILL BE EXPECTED TO PAY FOR ALL SERVICES RENDERED **BEFORE** ADEQUATE INSURANCE VERIFICATION.
3. THE FEE PAID FOR XRAYS IS FOR **ANALYSIS ONLY!** THE FILMS ITSELF IS THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSE, THEY **CANNOT** BE RELEASED WITHOUT PROPER WRITTEN CONSENT.
4. METHOD OF PAYMENT YOU PLAN TO USE TO TAKE CARE OF TODAY'S SERVICE?
Cash _____ Check _____ Charge _____

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