

**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), sustain from this work injury, 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 Work Injury: \_\_\_\_\_  
Has this work injury been reported to your employer? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_  
Please provide your supervisor's name: \_\_\_\_\_

**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