Maui Memory Clinic
2145 Wells St. Suite 202
Wailuku, Hi 96793
PH: (808) 244-1007
Fax (808) 442-0041
Dr.Tom@MauiMemoryClinic.com

Patient Information Form

Date: _____

PATIENT INFORMATION

NAME: _____ BIRTHDATE:_____ SEX: M/F
ADDRESS: _____
CITY:_____ STATE: _____ ZIP: _____
HOME PHONE:_____ CELL: _____
E-MAIL: _____.com SOCIAL SECURITY #: _____
MARITAL STATUS: _____ PRIMARY LANGUAGE: _____
RELIGION: _____
RACE (Circle One): HISPANIC BLACK/AFRICAN AMERICAN ASIAN WHITE EUROPEAN AMERICAN INDIAN NATIVE HAWAIIAN OR PACIFIC ISLANDER OTHER_____

EMPLOYMENT

EMPLOYER'S NAME: _____OCCUPATION: _____
EMPLOYER'S ADDRESS:_____
CITY:_____ STATE:_____ ZIP: _____
EMPLOYER'S PHONE #_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____
ADDRESS:_____ CITY:_____ STATE:_____
ZIP: _____ HOME PHONE #:_____ CELL PHONE #:_____

PRIMARY INSURANCE INFORMATION

INSURANCE: _____ POLICY#: _____ GROUP#:_____
ADDRESS: _____ CITY:_____ STATE:_____ ZIP: _____
PHONE #: _____

SECONDARY INSURANCE INFORMATION

INSURANCE: _____ POLICY#: _____ GROUP#:_____
ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____

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IF PATIENT IS OTHER THAN THE INSURED, PLEASE COMPLETE THIS SECTION
INSURED'S NAME_____
INSURED'S SOCIAL SECURITY #_____
RELATIONSHIP TO PATIENT_____INSURED'S DATE OF BIRTH_____
INSURED'S EMPLOYER_____INSURED'S EMPLOYER PHONE #_____
INSURED'S EMPLOYER ADDRESS_____

_____ I understand that insurance verification is not a guarantee of payment. Please initial.

_____ If Maui Memory Clinic submits any charges incurred at this facility to the patient's insurance company and said insurance company does not pay, I am as the guarantor, responsible for those charges. Please initial.

_____ If this appointment is regarding Financial Capacity, I understand that I am responsible for the full amount of $1,500, which is due on the day of my appointment as insurance does not cover testing for capacity. If court testimony is needed, additional fees will be incurred. A Fee schedule will be provided upon testimony request. Please initial or write N/A.

Maui Memory Clinic It is the policy of Maui Memory Clinic to comply with the requirements of the national, state, and organization framework for health information privacy protection for the purpose of providing information to family, friends, and other third party entities. In order to communicate your health status or permit any uses or disclosures of protected health information (PHI) to patient identified Family and Friends we will need your written permission.

_____ I agree to have Maui Memory Clinic communicate any uses and disclosures of PHI to my doctor, family and friends, providing they are involved with my care or payment of this visit.

Include:_____
(PCP/Neurologist/Psychologist/Psychiatrist, Family/Caregiver, Friend)
Exception:_____
(specify the person's name who will NOT be permitted to have access to PHI)

_____ I do *not* agree to have Maui Memory Clinic communicate any uses and disclosures of PHI to my doctor, family and friends upon request.

Signature:_____Date:_____
(Patient signature)

Signature:_____Date:_____
(POA/Guardian/Witness Signature)

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