MAKAI MOBILE REHAB

Patient Registration

7114 Niumalu Loop Honolulu, HI 96825
Phone (808) 783-9320 Fax (808) 396-5581

Name:

_____

(Last) (First) (M.I.)

Date of Birth: ___/____/_____ Male / Female

Doctor:_____

Patient Address:

_____

(Street) (Apt #)

_____

(City) (State) (Zip Code)

Social Security:_____
Home Phone:_____
Cell Phone:_____

Occupation:_____
Employer:_____

Emergency Contact Information

Name:_____
Relationship:_____
Address:_____

_____

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

Billing Information

(same as above)

Name on the account:

_____
Relationship:_____
Address:_____

_____

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

Insurance Information

Primary Medical Insurance Company:

_____
Subcriber Name:_____
Policy #:_____
Coverage code:_____
Subscriber's Date of Birth:___/___/_____
Secondary Medical Insurance Company:

_____

Assignment of Benefits

I hereby authorize assignment of my medical insurance benefits and/or my Medicare benefits to Makai Mobile Rehab, LLC for application to the bill for services furnished to me by that practitioner. I further authorize Makai Mobile Rehab, LLC to receive direct payment of all such benefit payments. I agree to remain responsible and liable for payments of all amounts due to Makai Mobile Rehab, LLC and not received from my insurance carrier(s). I SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

Signed:_____**Date:**_____

I hereby authorize the release of medical information requested for completion of medical claim form of the above mentioned insurance companies covering services rendered to the patient.

Signed:_____**Date:**_____