



Confidential Patient Information

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Name _____ DOB _____ Age _____
 Address _____ Apt _____ Phone _____
 City _____ State _____ Zip _____ Gender Male Female
 Permanent Address _____ Phone _____
 City _____ State _____ Zip _____ E-Mail _____
 Social Security # - - - D/L # _____ State _____
 Single Married Widowed Divorced Separated

If a minor, parent / guardian name _____

Social Security # - - - DOB - - -

Employer _____ Phone _____
 Address _____ Ext or Dept _____
 City _____ State _____ Zip _____ Hours _____
 Occupation _____ Supervisor _____

Spouse _____ DOB _____ Age _____
 Social Security # - - - Phone _____
 Employer _____ Work _____
 Address _____
 City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____
 Address _____ Phone _____
 City _____ State _____ Zip _____

Referring Physician _____ Next Visit _____

Primary Care Physician _____ Next Visit _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____