WORKSTAR Patient Information

Employee Initials ________

91-2135 Fort Weaver Road, Suite 150/170 * Ewa Beach, HI 96706 * (808) 576-5331 * Fax (808) 671-2931

PATIENT INFORMATION:

Last Name:	First Name:	Middle Initial:	Marital Satatus:
Address:	City/State:	Zip Code:	
Email Address:	Home Phone:	Work Phone:	Cell Phone:
Birth Date:	Sex: M ☐ F ☐	Social Security Num:	
Emergency Contact Name/Address:	Relationship to Emergency Contact:	Emergency Contact Phone:	

Who referred you to Workstar? PCP/doctor's name:

☐ Friend ☐ Family ☐ Patient ☐ Self

ACCIDENT / INJURY INFORMATION

Where you involved in an accident? Yes ☐ No ☐	If yes, please check the type of accident: Work ☐ Motor Vehicle ☐ Other ☐	Date of accident or injury:

EMPLOYMENT INFORMATION: (Required for all Worker's Compensation Injuries)

Employer Name:	Name of your supervisor:	Your job title:	Supervisor's phone num:
Work Address:	City/State:	Zip Code:	

ATTORNEY INFORMATION

Do you have an attorney for your accident or injury? Yes ☐ No ☐	If yes: Attorney's name:	Attorney's phone num:

INSURANCE INFORMATION

For *work related* injuries. Name of employer's Workers' Compensation Insurance: Phone:	WC Insurance Address:	Claim/Policy Num:	
		Name / ph. num. of Adjuster:	
For *motor vehicle related* injuries. Name of Auto Insurance: Phone:	NF Insurance Address:	COVG Code:	Claim/Policy Num:
		EFF Date:	Name / ph. num. of Adjuster:
For *Third Party Liability related* Injuries Place Where Injury Occurred: Phone:	TPL Insurance Address:	Claim/Policy Num:	
		Contact Person	
Primary *Private Insurance* Name: (All patients must fill out this information) Phone:	Primary Insurance Address:	COVG Code:	Claim/Policy Num:
		EFF Date:	Group Num.
Secondary *Insurance* Name: Phone:	Secondary Insurance Address:	COVG Code:	Claim/Policy Num:
		EFF Date:	Group Num.

OTHER INFORMATION

Smoking Status: ☐ Current everyday smoker ☐ Current some days smoker ☐ Smoker, current status unknown ☐ Never smoked ☐ Former smoker ☐ Smoker, current status unknown

Are you of Hispanic origin? ☐ Yes ☐ No | **Preferred Language:**

Please specify your ethnicity (Majority): ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Other ☐ Native Hawaiian/Pacific Islander

Authorisation to Release Information

To the extent reasonable and appropriate to establish liability for payment and to obtain reimbursement, I authorize Workstar Injury Recovery Center ('Workstar") to release any requested medical information or records to any person, organization, or agency which may be liable for payment of any portion of Workstar's fees and charges.

Financial Agreement:

I understand that I am financially responsible for all charges whether at not paid by said insurance. These include deductible, co-payments, cost-share and/or non covered benefits. I that the insurance information I provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

______________________ Signature

______________________ Date

______________________ Relationship to patient