WORKSTAR Patient Information

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

Office Use Only
Employee Initials:_____

Dear Valued Patient,

Health care costs continue to rise. Billing errors due to inaccurate and incomplete patient information contribute to this rise in costs for both patient and health care provider. Please help us to control costs by completely and accurately filling in the Patient Information Sheet below.

* If you do not have any of the requested information, please write a "*" in the space and be sure to provide it to us **BEFORE** your next office visit.
* Please fill in all the sections of this form. Write N/A for Not Applicable for any of the requested information that does not apply to your situation.

We reserve the right to deny treatment if all the required information is not received before your second visit.

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

Name or Primary Care Physician:

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

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

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:**	**Is this appointment for pain managment:** Yes ☐ No ☐
Do you have an attorney for your accident or injury? No ☐ Yes ☐	**If yes: Attorney's name:**	**Attorney's phone num:**	

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:**	

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.**

I certify 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 or Signature of Guardian**

_____ **Date**

_____ **Relationship to patient**

Print Form