EmPower Health

91-6390 Kapolei Parkway, Ewa Beach, HI 96706
Ph. (808) 691-3940 | Fax (808) 691-3955

Patient Information

Patient Name: Birthdate:

Address: Apt. #: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Email: Sex: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Partner ☐Separated ☐Divorced ☐Widowed

Social Security #: Emergency Contact: Relationship: Phone:

Ethnicity: Race: Pref. Language: Interpreter: ☐Yes ☐No Religious Preference:

Employer Name: Position:

Employer Address: City: State: Zip:

Guarantor Information *(List person or insured name responsible for bill)*

Name:

Relationship to Patient: Birthdate:

Address: Apt. #: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Social Security #: Sex: ☐Male ☐Female

Insurance Information

Primary Insurance: Policy #: Group #:

Subscriber Name: SSN: Sex: ☐Male ☐Female

Subscriber Address: City: State: Zip:

Patient's Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance: Policy #: Group #:

Subscriber Name: SSN: Sex: ☐Male ☐Female

Subscriber Address: City: State: Zip:

Patient's Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other

Accident Information: ☐Auto ☐Workers' Comp ☐Other Date of Accident:

Describe Injury:

Workers' Comp Insurance Name: Phone:

Workers' Comp Address: City: State: Zip:

PATIENT SIGNATURE/PATIENT REPRESENTATIVE____________________DATE__________RELATIONSHIP TO PATIENT____________________