HORMONE & LiFESTYLE OPTIMIZATION CLINIC
1600 Kapiolani Boulevard, Suite 500 ▪ Honolulu, HI 96814
PHONE 808 585-0785 FAX 808 942-7025 WEB LifeRestoreMD.com

PATIENT REGISTRATION

Today's Date: ____________________ **Referring Doctor or Patient:** _________________________

PATIENT INFORMATION

Patient Name**:** ____

Patient Address**:** ____
Street Address Apartment City State Zip Code

Home Telephone Number: _____________________ Sex: □ Female □ Male

Cellular Telephone Number: ____________________

Date of Birth:____________________ Marital Status: □ Single □ Married □ Other

Name of Spouse/Partner/Significant other: ____

Minors, name of parents: ____

Patient Social Security Number: _______________________

Patient Email address: _______________________________

EMPLOYMENT INFORMATION

Employer: ____________________________________ Occupation: ____________________________

Work Address: ____Telephone Number: _______________

Spouse Employer: ______________________________ Occupation:____________________________

Spouse Work Address: __________________________________Telephone Number:________________

If you are a minor:

Employer of Mother/Father/Guardian: ________________________________

Occupation: ________________

Address: ____

Employer Telephone Number: _________________________________

Social Security number of Mother/Father/Guardian: ___________________________________

EMERGENCY INFORMATION:

Person to notify in the event of an emergency:

Name: ____Relationship: _________________

Emergency Phone: _____________________

Address:____

INSURANCE / BILLING INFORMATION

To accurately file your insurance claims on your behalf the following information is needed, in addition to a copy of your card:

Primary Insurance Carrier: ___________________________________

Address: ____

Policy Number: _____________________Medical Code:_________________

Vision Code: __________________Group Number______________________

Subscriber Name: _________________________________ Relationship:_______________

Subscriber's Date of Birth: _____________________

Secondary Insurance Carrier: _________________________________

Address: ____

Policy Number: __________________ Medical Code:___________________

Vision Code: __________________Group Number______________________

Subscriber Name: ________________________________ Relationship:________________

Subscriber's Date of Birth: _____________________

Other Insurance Carrier: _____________________________________

Address: ____

Policy Number: __________________ Medical Code:___________________

Vision Code: __________________Group Number______________________

Subscriber Name: ________________________________Relationship:_______________

Subscriber's Date of Birth: _____________________

Assignment of insurance benefits: I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to the doctor for his charges. Purchased unused medical services will be reimbursed at 50% of the remaining program. Refunds are made to you at your mailing address within 30-60 days of the requested refund.

X_____________________________________ ______________________

Patient / Responsible Party's Signature Date (Required)