ADVANCED PACIFIC

71 Kanoa Street, Suite 101
Wailuku, HI 96793

advancedpacificent.com
808-244-5999

Account #: ______________________________ Date: ____________________

Patient Name:	DOB:	Gender: ☐ Male ☐ Female
Street Address:		
City:	State:	Zip:
Mailing Address:		
City:	State:	Zip:
Social Security #:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Home Phone:	Cell Phone:	Work Phone: Ext:
Employer:	Occupation:	Address:
If minor, name of parents: Parent 1:	Parent 2:	Guardian:
If married, spouse's name:	Employer:	Occupation:
Are you a student? ☐ Yes ☐ No ☐ Full-time ☐ Part-time	Name of School:	
Referring Doctor:	Primary Care Physician:	

RESPONSIBLE PARTY INFORMATION

Name:	Relationship to Patient:	Social Security #:
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone: Ext:
Employer:	Occupation:	Address:

MEDICAL INSURANCE INFORMATION

Primary Insurance:	Group #:	Coverage Code:	
Subscriber Name:	**Date of Birth:**	**Social Security #:**	**Employer:**
Secondary Insurance:	Group #:	Coverage Code:	
Subscriber Name:	**Date of Birth:**	**Social Security #:**	**Employer:**
Is this a work related injury? ☐ Yes ☐ No			

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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible, co-pay or any other balance not paid by your insurance company.

We request that charges for office visits be paid at the conclusion of the visit by either check, cash, or credit card.

If this account is assigned to any attorney for collection, and or suite, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my medical records to my insurance carrier. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and/or other health plans to Advanced Pacific. The assignment shall remain in effect until revoked by me in writing. A photo copy of this original assignment is to be considered as valid as the original.

I understand that I am financially responsible for charges whether or not paid by my insurance. I hereby authorize Advanced Pacific to release all information necessary to secure payment.

Signature of Responsible Party: ____ Date: __________

If signing as the responsible party, what is your relationship with the patient? ______________________