Ko'olau Audiology & Hearing Aid Services

808 263-4111
Fax: 808 263-4114

40 Aulike St., Ste 211 - Kailua, HI 96734

Acct #

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Other_____

Social Security #_____ Social Security # of Guardian (if minor)_____

Mailing Address (Street) _____

City _____ ST _____ ZIP_____

Email Address: _____

Spouse: _____ Work Phone # _____

Secondary Contact: _____ Phone #_____

Whom may we thank for referring you to our office? _____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Secondary Ins._____ _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Tertiary Ins._____ _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Who is financially responsible for this visit? _____ Phone # _____

I authorize Ko'olau Audiology & Hearing Aid Services to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Ko'olau Audiology & Hearing Aid Services of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____