

Advanced Reproductive Center of Hawaii

Christopher T.F. Huang, MD
 1319 Punahou Street, Suite 520, Honolulu, Hawaii 96826
 Phone: (808) 949-6611 Fax: (808) 949-6610

PATIENT INFORMATION SHEET

Marital Status: (Please ✓) Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/>				
PATIENT NAME (LAST NAME, FIRST):		SOCIAL SECURITY NO.:		BIRTHDATE:
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:	HOME PHONE:
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:	CELL PHONE:
EMPLOYER:		OCCUPATION:		
EMPLOYER'S ADDRESS:		BUSINESS PHONE:		
SPOUSE or PARENT (S) NAME:		OCCUPATION:		
SPOUSE'S EMPLOYER:		SPOUSE'S SOC. SEC. #	SPOUSE'S BIRTHDATE:	
SPOUSE'S EMPLOYER'S ADDRESS:		SPOUSE'S CELL PHONE:	SPOUSE'S BUSINESS PHONE::	
IN CASE OF EMERGENCY, NOTIFY:		RELATIONSHIP:		
		HOME PHONE:	BUSINESS PHONE:	
ETHNICITY [This information is voluntary, but greatly appreciated.]				

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT.
THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

INSURANCE INFORMATION:

TYPE OF INSURANCE	MEMBERSHIP/ POLICY #	GROUP #	COVERAGE CODE	EFFECTIVE DATE	SUBSCRIBER OF PLAN
1)					
2)					
3)					

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PATIENT INFORMATION SHEET Cont.

INSURANCE AUTHORIZATION AND ASSIGNMENT – PLEASE READ AND SIGN

I HEREBY AUTHORIZE CHRISTOPHER T.F.HUANG, MD TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE PHYSICIAN/S ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE:	DATE:
REFERRED BY:	

APPOINTMENT NOTICE – PLEASE READ AND SIGN

Office appointments are limited and therefore in consideration to other patients, if you are unable to keep your appointment please notify our office as soon as possible. A **\$25.00** late cancellation fee will be billed if you do not provide us with 24-hour notice for your cancellation or if you fail to show up for your appointment.

There will also be a \$25.00 service charge on all checks returned from your bank due to insufficient funds.

SIGNATURE:	DATE:
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