kaimukī CARE
physical therapy + rehabilitation

Confidential Patient Information

3221 Waialae Ave
Suite 360
Honolulu, HI 96816
Phone: (808)734-0020
Fax: (808)732-0010
www.kaimukicare.com

Name _____ DOB __-__-__ Age ____

Address _____ Apt ____ Phone __-__-____

City _____ State ____ Zip ____ Gender ☐ Male ☐ Female

Permanent Address _____ Phone __-__-____

City _____ State ____ Zip ____ E-Mail _____

Social Security # __-__-____ D/L # _____ State ____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If a minor, parent / guardian name _____

Social Security # __-__-____ DOB __-__-__

Employer _____ Phone __-__-____

Address _____ Ext or Dept ____

City _____ State ____ Zip ____ Hours ____

Occupation _____ Supervisor ____

Spouse _____ DOB __-__-__ Age ____

Social Security # __-__-____ Phone __-__-____

Employer _____ Work __-__-____

Address _____

City _____ State ____ Zip ____

Emergency Contact _____ Relationship _____

Address _____ Phone __-__-____

City _____ State ____ Zip ____

Referring Physician _____ Next Visit ____

Primary Care Physician _____ Next Visit ____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** ____