Hana Pono™
Wellness Center

2 Aarona Place Ste 202, Kailua, HI 96734 Ph: (808) 263-4343

Patient Information Date: _____

First Name: _____ MI: ____ Last Name: _____

Preferred Name: _____ DOB: _____ Age: _____ Sex: ◉ M ○ F

Email: _____ Phone: _____
(By providing an email address you authorize Hana Pono to contact you via the address provided)

Address: _____
City State Zip Code

Emergency Contact

Name: _____Phone:_____Relationship: _____

How did you hear about us? _____

Have you had any physical therapy this year? ○ Y ○ N If so, how many visits? _____

The reason for this visit is a result of: ○ work ○ auto accident ○ sports ○ other _____

Please describe your symptoms: _____

Insurance Information
The cost of your treatment may be covered in whole or in part by your insurance company. You are responsible for payment of any deductibles, co-pays or denied claims. Cash, check or credit card may be used for payment. There is a $25.00 fee for returned checks. _____ (initials)

Primary Insurance Company: _____

Policy Holder: (Last)_____ (First) _____ (M.I.) _____

DOB: _____ Relationship to policy holder: ○ Self ○ Spouse ○ Child ○ Other

Secondary Insurance Company: _____

Policy Holder: (Last)_____(First) _____ (M.I.) _____

DOB: _____ Relationship to policy holder: ○ Self ○ Spouse. ○ Child ○ Other

Employment Information

Occupation: _____

Employer: _____ Work Phone: _____

Employer's Address: _____
City State Zip Code.