Patti K. Murakami Endo, M.D.

1830 Wells Street, Suite 102 Wailuku, Hawaii 96793-2365
Telephone (808) 877-3635 Fax (808) 877-4363

PATIENT INFORMATION - *We protect your confidential personal information & keep it secure.* **DATE:**

PATIENT'S LEGAL NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER
OTHER NAME YOU WOULD LIKE TO BE CALLED (IF ANY)	☐ MALE ☐ FEMALE		PREFERRED CONTACT NUMBER ☐ HOME ☐ WORK ☐ CELL
LOCAL MAILING ADDRESS	CITY, STATE AND ZIP CODE		HOME TELEPHONE NUMBER
ALTERNATE MAILING ADDRESS	CITY, STATE AND ZIP CODE		MOBILE TELEPHONE NUMBER
PATIENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	WORK TELEPHONE NUMBER
PATIENT'S EMPLOYER'S STREET ADDRESS	CITY, STATE AND ZIP CODE		PREFERRED E-MAIL ADDRESS
SPOUSE'S NAME			SPOUSE'S CONTACT NUMBER
SPOUSE'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	WORK TELEPHONE NUMBER
SPOUSE'S EMPLOYER'S STREET ADDRESS	CITY, STATE AND ZIP CODE		
EMERGENCY CONTACT NAME	RELATIONSHIP TO YOU		EMERGENCY CONTACT NUMBER
WHO REFERRED YOU TO THIS PRACTICE	WHO IS YOUR FAMILY/PRIMARY CARE DOCTOR?		

IF PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	MOTHER'S DATE OF BIRTH	PREFERRED CONTACT NUMBER ☐ HOME ☐ WORK ☐ CELL
STREET ADDRESS	CITY, STATE AND ZIP CODE	HOME TELEPHONE NUMBER
MOTHER'S EMPLOYER	MOTHER'S SOCIAL SECURITY NUMBER	MOBILE TELEPHONE NUMBER
EMPLOYER'S STREET ADDRESS	CITY, STATE AND ZIP CODE	WORK TELEPHONE NUMBER
FATHER'S NAME	FATHER'S DATE OF BIRTH	PREFERRED CONTACT NUMBER ☐ HOME ☐ WORK ☐ CELL
STREET ADDRESS	CITY, STATE AND ZIP CODE	HOME TELEPHONE NUMBER
FATHER'S EMPLOYER	FATHER'S SOCIAL SECURITY NUMBER	MOBILE TELEPHONE NUMBER
EMPLOYER'S STREET ADDRESS	CITY, STATE AND ZIP CODE	WORK TELEPHONE NUMBER

INSURANCE INFORMATION

**PLEASE BRING YOUR CARDS TO EVERY APPOINTMENT.

PRIMARY INSURANCE NAME: SUBSCRIBER NUMBER:	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH
SECONDARY INSURANCE NAME: SUBSCRIBER NUMBER:	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH

AUTHORIZATION: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR MY PRIMARY OR SECONDARY INSURANCE BENEFITS BE MADE TO ME ON MY BEHALF **TO PATTI K. MURAKAMI ENDO, M.D.** FOR ANY SERVICE FURNISHED TO ME BY DR. ENDO. I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE COMPANY(IES) LISTED ABOVE FOR THE PURPOSE OF DETERMINING BENEFITS PAYABLE FOR THE RELATED SERVICES.
I UNDERSTAND THAT I AM FINANCIALLY REPSONSIBLE FOR ANY BALANCE (CO-PAYMENT, DEDUCTIBLE, HAWAII STATE TAX, ETC.) NOT COVERED BY MY INSURANCE CARRIER(S).

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN