M. Kathryn Schaefer, M.D.

Aina Hina Professional Building

850 W. Hind Drive Suite #102, Honolulu HI 96821

Phone: (808) 261-1121 Fax: 808-762-8392

NEW PATIENT INFORMATION (Welcome!)

Patient Name _____ _____ _____
Last First MI

Address _____ _____ HI _____
Street/Apt # City Zip Code

Phone: Home _____ Work _____ Cell _____

Email address _____

Birth Date _____/_____/_____ Age _____ SSN _____

Employer _____ Occupation _____

Emergency Contact _____ Phone _____ Relationship _____

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Primary Health Insurance _____ Subscriber No _____

Subscriber ☐ Myself, If not - Subscriber Name _____

Subscriber Birth Date _____ Relationship to Subscriber ☐ Spouse

Secondary Health Insurance _____ Subscriber No _____

Subscriber ☐ Myself, If not - Subscriber Name _____

Subscriber Birth date ____ / ____ / ____ Relationship to Subscriber ☐ Spouse ☐ Other _____

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Fill this section out only if you are being covered by Workman's Comp
Date of Injury _____ Is this a No Fault Claim ☐

Employer at time of your injury _____

Insurance Co _____ Case ID Number _____

Adjuster _____ Phone _____ Fax _____

Case Manager _____ Phone _____ Fax _____

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Assignment of Benefits – Release of Information

I hereby authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my claims to my insurance carrier(s), authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses. I understand that I or my authorized representative may receive a copy of this authorization upon request. I also authorize direst payment of benefits to my physician. I understand that I am financially responsible for all charges whether or not covered by insurance. I agree that these will be a charge for an office visit if the office is not notified of a cancellation at least 24 hours before that visit.

Signature _____ Date _____