The LD-ADHD Center of Hawaii
98-1268 Kaahumanu Street, Suite 202
Pearl City, HI 96782
Phone: 808-955-4775 Fax: 808-955-3130

THERAPY PATIENT REGISTRATION

Date: ____________________

Name: ________________________________ Other names used: ______________________________

DOB: __________________ Gender: M or F Marital Status: _____________

Address: ____
(Street) *(City)* *(Zip)*

Phone: Home: __________________ Cell: ____________________ Other: __________________

Email Address: ____

Medical/psychological diagnosis, physician, and date (if any):

____

Briefly describe the problems or symptoms: ____

____

What specific questions would you like answered?

____

Primary Health Insurance: ___________________ Subscriber Name: ______________________

Subscriber ID #: ____________________________ Subscriber DOB: _______________________

SSN: _____________________________________

Secondary Health Insurance: _________________ Subscriber Name: ______________________

Subscriber ID #: ____________________________ Subscriber DOB: _______________________

This form was completed by: Patient: Y or N Other: _______________________________
If not completed by the patient, please provide the following information:

Name: _______________________________ Address: _______________________________

Phone: _______________________________ Relation: _______________________________