HAWAII INJURY RECOVERY CENTER

Hawaii Injury Recovery Center
Patient Information

Last Name:_____First Name:_____Middle Initial: _____

Address:_____City:_____State:_____

Email:_____ Zip Code:_____

Phone: (Home)_____(Work)_____(Cell)_____

Birth Date:_____ Sex: ☐ Male ☐ Female

Emergency Contact Name:_____ Phone:_____

Relationship:_____

Insurance Company:_____ Phone:_____

Insurance Address:_____

Claim/Policy #_____ Coverage Code:_____

Adjustor_____ Date of Injury:_____

Adjustor's Phone Number_____

Secondary Insurance:_____ Phone:_____

Claim/Policy #_____ Coverage Code:_____

Group #_____ Effective Date:_____

I certify that the insurance information I provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

_____ _____

Signature Date