Iris
INTEGRATIVE HEALTH
*65-1235A Opelo Rd. #6*
*Kamuela, HI 96743*
*Ph: (808) 887-1210*
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# Patient Information Sheet

Patient Name:_____Date of Birth:_____ Sex:_____
MailingAddress:_____City, State, Zip:_____
Physical Address:_____City, State, Zip:_____
Phone:(  )_____ Cell: (  )_____ Email: _____
Social Security: _____ Marital Status: Single Married Other
Preferred Language:_____Ethnicity (optional):_____
Occupation:_____Employer:_____
Phone:(  )_____Address: _____

Primary Insurance: _____Policy#:_____
Subscriber:_____ (i.e. self/name of spouse)Date of Birth:_____ Sex:_____
Secondary Insurance: _____Policy#:_____
Subscriber:_____ (i.e. self/name of spouse)Date of Birth:_____ Sex:_____

Emergency Contact:_____Phone: (  )_____Relationship: _____
I authorize release of medical confidential information to the following persons (optional):
1. Name: _____ Phone: (  )_____Relationship: _____
2. Name: _____ Phone:(  )_____Relationship: _____

I verify that the above information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to: White Mountain Health, LLC (doing business as Iris Integrative Health) for any services furnished to me.

Signature:_____Date:_____

I authorize Iris Integrative Health to disclose/request my health information, including copies of records necessary to/from:

1. Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.
2. Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other providers for the purpose of continuity of care.
3. Any insurance company that provides liability insurance coverage for Iris Integrative Health to evaluate clinical performance.
4. Any worker's compensation, no fault or administrative proceeding for the purpose of evaluating my medical condition.

All medical information, with no exception, will be disclosed/requested as necessary to/from the above. I authorize faxing information as necessary. This authorization shall cover the period of time from my first visit to my last visit, and will end 2 years after the date of last visit. I permit a copy of this authorization to be used in place of the original.

Signature:_____Date:_____