The LD-ADHD Center of Hawaii, LLC
98-199 Kamehameha Hwy., Suite E-7
Aiea, HI 96701
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):

1) _____ 3) _____

2) _____ 4) _____

Briefly describe the problems or symptoms: _____

_____

What specific questions would you like answered?

1) _____

2) _____

3) _____

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: _____