Health Quest Therapy, Inc.
formerly Maui Hand Therapy

Patient Registration

Patient Information

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ SS# _____ Gender: ☐ Male ☐ Female

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Local Address: _____

Mainland Address: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Primary Physician: _____

Diagnosis: _____ Email : _____

Place of Employment: _____ Attorney: _____

Affected Side: ☐ Right ☐ Left ☐ Both Dominant Side: ☐ Right ☐ Left ☐ Both

Date of Injury: _____ Did You Have Surgery: ☐ No ☐ Yes, Date of Surgery: _____

Nature of the Accident or Injury: _____

Accident related: ☐ Auto ☐ Work Next Doctors Appointment: _____

Insurance Information

Primary Insurance: _____ Subscriber Name: _____

Membership/Claim#: _____ Group #: _____

Adjusters Information: _____ Phone: _____

Fax: _____

Secondary Insurance: _____ Subscriber Name: _____

Membership/Claim#: _____ Group #: _____

Copay: _____

Comments: _____

1325 S Kihei Rd, Ste 102, Kihei, Hawaii 96753 • phone: 808-269-1720 fax: 866-431-9522