Craig H. Robinson, Ph.D, Inc.
Century Square, Suite 2702, 1188 Bishop Street
Honolulu, Hawaii 96813
Phone (808) 533-6133
Fax (866) 780-9015
craig@craigrob.com

Intake Form

Name: _____ Date ___/___/___

Address: _____ City:_____

Zip Code: _____ Phone Residence: _____ Business: _____

E-Mail: _____ Date of Birth: ___/___/___

Occupation: _____ Employer:_____

Marital Status: (circle) Single Married Widowed Divorced Separated

Name of Spouse: _____ Occupation:_____

Date of Birth: ___/___/___ Phone Residence: _____ Business: _____

Employed by:_____

Referred to this office by: _____

You have my permission to thank the person who referred you: YES NO

Medical Insurance: _____Policy No._____

Subscriber: _____

Preferred Method of Payment: Master Charge_____ Visa _____ AmExp
Cash_____ Personal check _____ Other_____

Please stop at this point and read the handout Frequently Asked Questions and Conditions of Evaluation and Treatment, which is yours to keep for your records.

Please check one of the items below:

_____ I have read and understand, and agree to the conditions described in Frequently Asked Questions and Conditions of Evaluation and Treatment. I have also been shown and offered a copy of the *Notice Form*. I authorized the release of any information requested for completion of my medical claim form to the above insurance company covering services.
_____ Before signing, there are some issues I would first like to discuss with Dr. Robinson.

Signature:_____ Date: ____/____/____

For Office Use Only
DX#:_____ Co-Pmt:_____
Cov: _____ CPT:_____