HAWAII WHOLE PERSON
HEALING COLLECTIVE, LLC

Christopher Lawinski, MD
808-936-1156

Patient First Name: _____ Last Name: _____

Guardian Name (if minor or in custody): _____

Mailing Address: _____ City: _____ State: _____ ZIP:

_____ Email:_____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____

Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Place of Birth:_____ (city and state; provide country if outside U.S.)

Occupation: _____ Sex: _____

Referred by: ☐ Website ☐ Storefront ☐ Friend or Family
☐ Flyer ☐ Physician ☐ Other

Emergency Contact: Name_____ Phone Number_____

Physicians: Name_____ Phone Number _____

Name_____ Phone Number_____

Primary Health Insurance :_____

Secondary Health Insurance: _____

Motor Vehicle Accident Insurance:_____ Claim Number:_____

Adjuster Name :_____ Phone Number :_____

Today's Date _____