Hawai'i Infectious Disease Associates
Heath Chung, MD./Eric Kajioka MD./Benjamin Thomas, MD./James Joyner, MD
John Raymond Go, MD./ Lorrance Majewski, DO.

500 Ala Moana Blvd., Tower 5, Suite #300 Honolulu, HI 96813
O: (808) 531-7111/ F: (808) 528-5507

Workers Compensation Form

Patient Information

Last Name:________________________, First Name:________________________, MI_____

Date of Birth:_______________________, SSN#________________________ [ ] M / [ ] F

Address:____

City, State, Zip:____

Home Phone: ( )_____________________, Cell Phone: ( )_______________________

Emergency Contact: ( )_____________________, Relationship:_____________________

Marital Status: [ ] Single [ ]Married [ ]Widowed [ ] Other__________________________

Employer:______________________________, Did you report your accident? [ ]Yes [ ] No

Supervisor:_____________________________, Phone Number: ( )___________________

Company Insurance Carrier: ____

Address:____

City, State, Zip:____

Claim Adjuster:_____________________________, Phone Number: ( )_______________

Claim #____________________________________, Date of Injury:____________________

Time:_____________________________________, Location:__________________________

How did this injury occur? *Please describe fully the event that resulted your injury*

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Please bring in a copy of your HI-DL/ID, and Claim Number with the Incident Report

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No Fault Form

Patient Information

Last Name:________________________, First Name:________________________, MI_____

Date of Birth:_______________________, SSN#________________________ [ ] M / [ ] F

Address:____

City, State, Zip:____

Home Phone: ( )_____________________, Cell Phone: ( )______________________

Emergency Contact: ( )_____________________, Relationship:_____________________

Marital Status: [ ] Single [ ]Married [ ]Widowed [ ] Other__________________________

Auto Insurance Carrier: ____

Address:____

City, State, Zip:____

Auto Claim Adjuster:_______________________, Phone Number: ( )________________

Auto Claim #_______________________________, Date of Accident:___________________

Time:___________, Location:________________Did you file a police report? [ ] Yes [ ] No

Police Report #___________________,Other Party Involved___________________________

Auto Insurance Carrier________________, Phone #( )____________________________

How did this auto accident occur? *Please describe fully the event that resulted your injury*

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Please bring in a copy of your HI-DL/ID, and Claim Number with the Auto Accident Report

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Third Party Liability Form

Patient Information

Last Name:_________________________, First Name:_________________________, MI_____

Date of Birth:_________________________, SSN#_________________________ [ ] M / [ ] F

Address:____

City, State, Zip:____

Home Phone: (   )______________________, Cell Phone: (   )______________________

Emergency Contact: (   )______________________, Relationship:______________________

Marital Status: [ ] Single [ ]Married [ ]Widowed [ ] Other___________________________

TPL Insurance Carrier: ____

Address:____

City, State, Zip:____

TPL Claim Adjuster:_______________________, Phone Number: (   )___________________

TPL Claim #______________________________, Date of Incident/Injury:__________________

Time:____________, Location:_________________Did you file a police report? [ ] Yes [ ] No

Police Report #____________________,Other Party Involved__________________________

How did this incident/injury occur? *Please describe fully the event that resulted your injury*

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Please bring in a copy of your HI-DL/ID, and Claim Number with the Incident/Accident Report