NATHAN FUJITA MD. | **OBSTETRICS & GYNECOLOGY**
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REGISTRATION SHEET

Account #

1

Patient's **Legal** Last Name , **Legal** First Name Middle Initial Name prefers to be called

Street Address Apt # ☐ Single ☐ Married ☐ Widowed ☐ Divorced

City State Zipcode _____-_____-_____ Social Security Number _____ /_____ /_____ Month Date Year

Home Phone # Phone # blocked? Yes / No Which number is best to contact you? ☐ Home ☐ Pager ☐ Cell ☐ Business

Cell Phone # Pager #

Referred by Email

2

Employer Occupation

Business Address Business Phone # Ext #

Spouse's Name Employer Business Phone #

Emergency Contact Relationship to Patient Phone #

3

Responsible Party / Authorized Agent / Legal Guardian (if minor) Relationship to Patient

Street Address Apt # Home Phone #

City State Zipcode Business Phone # Ext #

4

Primary Insurance / HMO Health Center Subscriber Name Subscriber Birthdate Sex: M / F

Policy # Group / Medical Coverage # Drug Coverage # Relationship to Patient

Primary Insurance / HMO Health Center Subscriber Name Subscriber Birthdate Sex: M / F

Policy # Group / Medical Coverage # Drug Coverage # Relationship to Patient

I hereby certify that the information given on this form is true and correct to the best of my knowledge. I authorize the use and disclosure of my protected health information (PHI) to carry out treatment, payment, health care operations and other purposes that are permitted or required by law. I understand that I am financially responsible for all charges incurred and will guarantee payment if my insurance does not pay all bills submitted. In the event that insurance payments are sent directly to me, I will remit payment to this office. I also agree to pay any attorney/collection costs incurred, in the event my account becomes delinquent.

Signature of Patient / Responsible Party / Legal Guardian / Authorized Agent Date _____ /_____ /_____ Month Day Year

Revised 04/28/2016