Carla Nip-Sakamoto, M.D. **Miki Shirakawa Garcia, M.D.**

1329 Lusitana Street, Suite 109 Honolulu, Hawaii 96813

CONFIDENTIAL PATIENT REGISTRATION FORM

(Please Print)

Today's Date: / /

Primary Care Physician:

PATIENT INFORMATION

Mr. Mrs. Miss Ms. (circle one)	Patient's Last Name	First	MI:	Marital status (circle one) Single Married Div Widow Other

Street Address/Apt #:	City/State/Zip Code	Birth Date:	Age	Gender: M F (circle one)

Home Phone:	Cell Phone:	Work:	SSN:	Spouse's Name:

May we leave messages regarding your health care and services on your answering machine, including appointment reminders? Yes No

Email Address:

Occupation: Employer:

Person Responsible for Bill:	Occupation:	Home Phone: Cell/Work:

Address If Different from Above:

Who referred you Here?

Other Family Members Seen Here:

In Accordance with CMS "Meaningful Use" Requirements, we are obliged to gather the following information. You may decline to answer if you would rather not provide this information.

Race/Ethnicity (circle):
Asian African American Hispanic
American Indian Caucasian
Native Hawaiian/Pacific Islander
Decline to Answer

Primary Languages Spoken:

INSURANCE INFORMATION

(Please Give Your Insurance Card to the Receptionist)

Primary Insurance

Insurance Name: _____ Insurance ID#: _____

Subscriber Name: _____ Subscriber Birth Date: _____

Patient's Relationship to Subscriber: (circle one) Self Spouse Child Other

Secondary Insurance

Insurance Name: _____ Insurance ID#: _____

Subscriber Name: _____ Subscriber Birth Date: _____

Patient's Relationship to Subscriber: (circle one) Self Spouse Child Other

IN CASE OF EMERGENCY

Name of Friend or Relative to Contact In Case of Emergency _____

Relationship to Patient _____

Home/Cell/Work Phone Number _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially repsonisble for any balance. I also authorize Carla Nip-Sakamoto MD, Miki Garcia MD, or the insurance company to release any information required to process my claims. To establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment poilicies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered unless you are in a prepaid health insurance in which we participate. For those patients, applicable insurance copayments and deductibles will be collected at the time services are rendered. We accept payment in the form of cash, check, Visa, or Mastercard.

Patient/Guardian Signature _____ Date _____