Carla Nip-Sakamoto, MD Miki Shirakawa Garcia, MD Summer Chong, MD

1329 Lusitana Street, Suite 109 Honolulu, Hawaii 96813

CONFIDENTIAL PATIENT REGISTRATION FORM

(Please print)

Today's Date: / /	Primary Care Physician:

PATIENT INFORMATION

Patients last name	**First name**	**MI**	Marital Status (circle one) Single Married Div Widow Other

Street Address/Apt#	City/State/Zip Code	Birth Date	Age	Gender M F

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

May we leave messages regarding your health care and services on your answering maching, including appointment reminders? YES ___ NO ___ Can we send you e-mail regarding special promotions? Yes __ NO ___	E-mail address:

Occupation:	Employer:

Person Responsible for Bill (Guarantor)	Occupation:	Home Phone: Cell/Work:

Billing /mailing 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 date of birth: _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

SECONDARY INSURANCE:

Insurance Name: _____ Insurance ID # _____

Subscriber Name: _____ Subscriber date of birth: _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

IN CASE OF EMERGENCY

Name to contact in case of emergency _____

Relationship to patient: _____ Home/Work/Cell Phone Number: _____

The above information is true to the best of my knowldege. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carla Nip-Sakamoto,MD, Miki Garcia, MD and Summer Chong, MD or the insurancecompany to release any information required to process my claims. To release optimal relations with our patients and avoid misunderstandingand confusion regarding our payment policies, our staff is trained to cinsistently inform you of the financial payment policies of this office.Payment is required for services at the time the are rendered unless you are in a prepaid health insurance un which we participate. For thosepatients, applicable insurance copayments and decuctibles will be collected at the time services are rendered. We accept payment in the formof cash, check and credit cards.

Patient/Guardian Signature: _____ Date: _____