

Nihon Bay Clinic

Registration Sheet

患者登録書

PATIENT'S INFORMATION 患者インフォメーション

日付
DATE:

患者氏名 (フリガナ ローマ字)

Last Name (漢字): _____ First Name (漢字): _____ Social Security #: _____

誕生日 年 月 日 年齢: 性別 男-M、女-F 独身 既婚
Patient's Birth Date: _____ Sex: _____ Single Married

世帯主名 (フリガナ ローマ字) 患者(又は世帯主)勤務先
Guarantor's Full Name (漢字): _____ Employer: _____

自宅住所 勤務先住所
Home Address: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

自宅電話 勤務先電話
Home Phone: (_____) Work Phone: (_____)

携帯番号
Cell Phone (_____)

INSURANCE INFORMATION 医療保険インフォメーション

保険会社 保険証券番号
Insurance Plan Name: _____ Insured's ID #: _____ Group #: _____

被保険者(保険の対象となる方)氏名 性別 誕生日
Subscriber's Full Name: _____ Sex: _____ DOB: _____ Social Security #: _____

被保険者との関係 自身 夫婦 子供 その他 第2保険会社
Relationship to Subscriber: Self Spouse Child Other Secondary Insurance Plan Name: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize to release any information in the course of my treatment or examination to my insurance carrier(s).

ASSIGNMENT OF BENEFITS:

I hereby authorize payment to Physician of Benefits due me for a services rendered. I understand that I am responsible for charges NOT COVERED by this insurance plan/authorization.

SIGNED: _____ 

SIGNED: _____ 

EMERGENCY CONTACT 緊急連絡先

緊急時連絡者 患者との関係 夫婦 子供 その他
Contact Person's Name: _____ Relationship to Patient: Spouse Child Other

連絡者住所 自宅電話
Home Address: _____ Home Phone: _____

連絡者勤務先 勤務先電話
Employer: _____ Work Phone: _____

勤務先住所
Employer's Address: _____

All statements for services rendered are due and payable within thirty (30) days of the date of statement. The undersigned agrees and consents to pay all statements within ninety (90) days or to pay an additional late payment charge of 1.5% per month (an annual rate of 18%) for any unpaid balance after the initial ninety (90) day period. The undersigned further agrees to pay any and all attorney fees, costs and expenses incurred by Nihon Bay Clinic in collecting balances unpaid for more than 90 days.

SIGNATURE OF RESPONSIBLE PARTY : _____ 