

Nihon Bay Clinic Registration Sheet

(Co-nav \$)

患者登録書 (小児科)

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 (又は患者保護者) 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: ()

E-mail :

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 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 : _____ 