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（ﾌﾘｶﾞﾅ 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 離婚 未亡人

Patient's Birth Date: Age: Sex: Single Married Divorced Widowed

世帯主名（ﾌﾘｶﾞﾅ ﾛｰﾏ字）
Guarantor's Full Name（漢字）:

患者（又は世帯主）勤務先 *必須
Employer:

自宅住所
Home Address:

勤務先住所
Employer's Address:

City: State: Zip:

City: State: Zip:

自宅電話
Home Phone: ( )

勤務先電話
Work Phone ( )

携帯番号
Cell Phone ( )

メール
E-mail :

EMERGENCY CONTACT (*required) 緊急連絡先

緊急時連絡者
Contact Person's Name:

患者との関係 夫婦 子供 その他
Relationship to Patient: Spouse Child Other

連絡者住所
Home Address:

電話番号
Phone#:

INSURANCE INFORMATION 医療保険インフォメーション

保険会社
Insurance Plan Name:

保険証券番号
Insured's ID #: Group #:

被保険者（保険の対象となる方）氏名
Subscriber's Full Name:

性別 誕生日
Sex: DOB: Social Security #:

被保険者との関係 自身 夫婦 子供 その他
Relationship to Subscriber: Self Spouse Child Other

第2保険会社
Secondary Insurance Plan Name:

PHARMACY *required 薬局 (CVS, Walgreens, Target, Costco, Safeway, etc..)

Name 名前 Address 住所 Phone #:

REFERRAL INFORMATION 紹介者

☐ Internet インターネット: ☐ Insurance 保険会社:

☐ TV/Newspaper テレビ・新聞: ☐ Friends 知人: ☐ Other その他:

Consent 同意 ＊Please initial next to ☐ and sign below. ボックスの横にイニシャルをして、サインをして下さい。

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

☐ ______ I hereby authorize payment to physician of benefits due me for a services rendred. I understand that I am responsible for charges NOT COVERED by this insurance plan/authorization.

☐ ______ 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 :