

# Nihon Bay Clinic

## Registration Sheet

### 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

Patient's Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

世帯主名 (フリガナ ローマ字)

Guarantor's Full Name (漢字): \_\_\_\_\_

自宅住所

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

自宅電話

Home Phone: ( ) \_\_\_\_\_

Mom's Cell # ( ) \_\_\_\_\_

Dad's Cell # ( ) \_\_\_\_\_

患者保護者 勤務先

Employer: \_\_\_\_\_

勤務先住所

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

勤務先電話

Work Phone: ( ) \_\_\_\_\_

E-mail : \_\_\_\_\_

#### EMERGENCY CONTACT 緊急連絡先

緊急時連絡者

Contact Person's Name: \_\_\_\_\_

連絡者住所

Home Address: \_\_\_\_\_

連絡者勤務先

Employer: \_\_\_\_\_

患者との関係

Relationship to Patient: \_\_\_\_\_

自宅電話

Home Phone: \_\_\_\_\_

勤務先電話

Work 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

Sex: \_\_\_\_\_

誕生日

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

被保険者との関係

Relationship to Subscriber: \_\_\_\_\_

その他

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 rendered. 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 :**

