Date:_____

Registration Form

Curtis Takemoto-Gentile, MD ♦ Krishanna Takemoto-Gentile, MD

PATIENT INFORMATION

Last Name:	First:	Middle:	Social Security No:		
Address:			Marital Status (circle one) ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed		
City:	State:	ZIP Code:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Primary Phone: ( )	Secondary Phone: ( )	May we leave Voicemail Messages? ❑ Y ❑ N			
Email Address:	Do you have an Advanced Directive? (*If yes, please provide the office with a copy)* ❑ Yes ❑ No	Primary Language: ❑ English ❑Other_____			

Race: (*please check ONE*)

❑ Native Hawaiian	❑ Hispanic	❑ American Indian or Alaska Native	
❑ White	❑ Black or African American	❑ Other Race	
❑ Asian	❑ Pacific Islander	❑ I Decline to Answer	

Ethnicity: *(please check ONE)*

- ❑ Non Hispanic
- ❑ Hispanic or Latin
- ❑ Refuse to Report

EMPLOYMENT AND INSURANCE INFORMATION

Occupation:	Employer:		
Employment Status (circle one): ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired			
Employer Address:	Employer Phone No: ( )		
Person responsible for bill:	Birth Date: / /	Home Phone: ( )	
Address of Person Responsible for the bill (if different from above):	City:	State:	Zip Code:

Primary Insurance Provider:	Subscriber's Name:		
Subscriber's Birth Date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Secondary Insurance Provider (if applicable):	Subscriber's Name:		
Subscriber's Birth Date: / /	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY			
Name:		Relationship to patient:	
Address:	City:	State:	ZIP Code:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	

RELEASE OF MEDICAL RECORDS AND INFORMATION AUTHORIZATION

Do you authorize the release of your medical records to anyone other than yourself?
(This includes people that you may have call our office to schedule appointments, refill medications, etc.)

❑ Yes ❑ No

If so, please list person(s) names:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

_____ _____

PATIENT** or Guardian Signature (for those under 18 years of age)* ***Date

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

I have read and/or received a copy of the Notice of the Use and Disclosures of Protected Health Information that is available in the office. I hereby acknowledge that I may receive from Curtis Takemoto-Gentile, M.D. a copy of the Notice (HIPAA privacy policy). **Please see receptionist for copy**

_____ _____

PATIENT** or Guardian Signature (for those under 18 years of age)* ***Date