

# CURTIS TAKEMOTO-GENTILE, MD

## REGISTRATION FORM

Date: \_\_\_\_\_

### PATIENT INFORMATION

Last Name:		First:	Middle:	Social Security No.:	
Address:				Marital Status (circle one) Single / Mar / Div / Sep / Widowed	
City:	State:	ZIP Code:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Primary Phone: ( )	Secondary Phone: ( )	May we leave Voicemail Messages? <input type="checkbox"/> Y <input type="checkbox"/> N			
Email Address:		Do you have an Advanced Directive? <i>(If yes, please provide the office with a copy)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Race: <i>(please check ONE)</i> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Other Race <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> I Decline to Answer			Ethnicity: <i>(please check ONE)</i> <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance Provider (if applicable):		Subscriber's Name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

### IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Address:	City:	State:	ZIP Code:

### RELEASE OF MEDICAL RECORDS AND INFORMATION AUTHORIZATION

**Do you authorize the release of your medical records to anyone other than yourself?**     Yes     No

**If so, please list person(s) names:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**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**