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: ❑ 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:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ 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***