

## Registration Form

(Please Print)

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

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

Home Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widow

Occupation:  
\_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

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

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

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

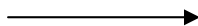
Relationship: \_\_\_\_\_

### PRIMARY INSURANCE

Insurance: \_\_\_\_\_ Subscriber # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

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

CONTINUED 

**SECONDARY INSURANCE**

Insurance: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

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

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I have insurance coverage with the above listed insurance companies and assign directly to Renee L. Sato MD, LLC all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. If I change insurance coverage while health care is provided, I understand that I will be responsible for all costs incurred if I fail to inform the doctor. If I do not have valid insurance at the time of services rendered, then I am responsible for all charges.

If Medicare covers me, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

A photocopy of this Assignment and Release shall be considered as effective and valid as the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_