Renee L. Sato MD, LLC
Queen's Physician's Office Building 1
1380 Lusitana Street, Suite 504
Honolulu, Hawaii 96813

# 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: υ Single υ Married υ Divorced υ Separated υ 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: _____