

MELVIN M.K.W. HAYASHI, M.D.

DWITE D. DAHMS, M.D.

PIERRE DURAND, M.D.

GARY A. PATTEE, M.D.

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS!

IS YOUR CONDITION A RESULTS OF A WORK INJURY? YES NO AN AUTO ACCIDENT? YES NO

PATIENT'S PERSONAL INFORMATION

Name \_\_\_\_\_ Marital Status: S M D W P (separated)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_ Cell Phone( ) \_\_\_\_\_

Sex: M F Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  
Month Day Year

Occupation \_\_\_\_\_

Employer/School Name \_\_\_\_\_ Driver's License: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Retirement \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Work Phone( ) \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Retirement \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

Responsible Party \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Relationship to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_ Cell Phone( ) \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone Number( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Your Occupation \_\_\_\_\_ Date of Retirement \_\_\_\_\_

Spouse's Employer Name \_\_\_\_\_ Phone Number( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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PATIENTS'S INSURANCE INFORMATION

Please present ALL insurance cards

PLEASE PRINT AND COMPLETE ALL SECTIONS!

Primary insurance company's name \_\_\_\_\_

Insurance address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number(    ) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Sex: M    F    Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month    Day    Year

Relation to insured: Self    Spouse    Child    Other \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group Name \_\_\_\_\_ Group# \_\_\_\_\_

SECONDARY insurance company's name \_\_\_\_\_

Insurance address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number(    ) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Sex: M    F    Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month    Day    Year

Relation to insured: Self    Spouse    Child    Other \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group Name \_\_\_\_\_ Group# \_\_\_\_\_

Check if appropriate: Retiree coverage \_\_\_\_\_ Medigap policy \_\_\_\_\_

PATIENT'S REFERRAL INFORMATION

Referred by \_\_\_\_\_ Your Primary Physician \_\_\_\_\_

EMERGENCY CONATACT

Name of person not living with you \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(    ) \_\_\_\_\_ Work Phone(    ) \_\_\_\_\_ Cell Phone(    ) \_\_\_\_\_

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**RELEASE AND ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT**

I hereby give authorization for payment of insurance benefits to be made directly to HAYASHI, DAHMS, DURAND, AND PATTEE, M.D.'s for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I also authorize the release of my medical records and any information regarding myself to any Physician, Dentist, or Insurance Company,

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

Authorization to Treat a Minor: I hereby authorize HAYASHI, DAHMS, DURAND, AND PATTEE, M.D.'s to perform physical examination, laboratory investigations, or other therapeutic treatment on my child.

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

I consent to and authorize any treatment that is necessary for my medical care.

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Hayashi, Dahms, Durand, and Pattee.

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

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Hayashi, Dahms, Durand, and Pattee, state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

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

**SUMMARY OF OUR FINANCIAL POLICY**

I, \_\_\_\_\_, have received the Summary of Financial Policy from Hayashi, Dahms, Durand, and Pattee.

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