ALLISON SHIGEZAWA MD

PATIENT REGISTRATION

TODAY'S DATE:

PATIENT INFORMATION:

Patient Name: _____

Patient Address: _____

Street Address Apartment City State Zip Code

Home Telephone Number: _____ Sex: ☐Female ☐Male

Work: _____

Cell Number: _____

Date of Birth:____/_____/____ Marital Status: ☐Single ☐Married ☐Other

Name of Spouse: _____

Minors, name of parents: _____

Patient Email address: _____

EMPLOYMENT INFORMATION:

Employer: _____ Occupation: _____

Work Address: _____ Telephone Number: _____

Spouse Employer: _____ Occupation: _____

Spouse Work Address: _____ Telephone Number: _____

IF YOU ARE A MINOR:

Employer of Father/Guardian: _____

Occupation: _____

Address: _____

Employer Telephone Number: _____

Social Security number of Father/Guardian: _____

Employer of Mother/Guardian: _____

Occupation: _____

Address: _____

Employer Telephone Number: _____

Social Security number of Mother/Guardian: _____

EMERGENCY INFORMATION:

Person to notify in the event of an emergency:

Name: _____

Relationship: _____

Emergency Phone: _____

Address: _____

INSURANCE / BILLING INFORMATION

To accurately file your insurance claims on your behalf the following information is needed, in addition, to a copy of your card. Please see a staff member for assistance if you have any questions. Please hand our receptionist your insurance card so we can keep a copy in your files.

Primary Insurance Carrier: _____

Address: _____

Policy Number: _____ Medical Code: _____

Vision Code: _____ Group Number: _____

Relationship: _____

Subscriber's Date of Birth: _____

Secondary Insurance Carrier: _____

Address: _____

Policy Number: _____ Medical Code: _____

Vision Code: _____ Group Number: _____

Subscriber Name: _____

Relationship: _____

Subscriber's Date of Birth: _____

Other Insurance Carrier: _____

Address: _____

Policy Number: _____ Medical Code: _____

Vision Code: _____ Group Number: _____

Subscriber Name: _____

Relationship: _____

Subscriber's Date of Birth: _____

Authorization to release information: I hereby authorize the doctor to furnish the insurance company any information that they may request concerning my present claim.
Assignment of insurance benefits: I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to the doctor for his charges.

Patient / Responsible Party's Signature Date (Required)

FINANCIAL AND INSURANCE INFORMATION

PLEASE READ CAREFULLY

The best medical care can be provided only on the basis of mutual understanding.
We encourage you to discuss any question you may have regarding our policies with our billing staff.
Please present ALL insurance cards to the receptionist to retain in your files.
Our office participates with many different insurance carriers. To assure proper processing of your claims, up-to-date insurance information must be received.

Any and all quotes given will be on the presented based on the insurance at the time of your visit and are estimates only. We will file your claims for you. Should your visit be denied by your insurance company, you will be responsible for the remaining balance on your account.
Our office will not be responsible for any insurance denials or rejections based upon previous visits to other doctors on your current plan. If your visits are denied, payment in full is expected upon notification.
I have read, understood and agreed to the above

Patient / Responsible Party's Signature Date (Required)

PATIENT PRIVACY INFORMATION/AUTHORIZATION NOTIFICATION

In order to provide you with the best care possible. Dr. Shigezawa may consult with another physician regarding your examination, treatment and history. Your exam results, lab results and other private information may also be share in order to treat you properly. You may also be referred to another specialist and or back to you PCP (Primary Care Physician) for treatment and consultation at which time information will be shared with that physician.
In order to release any such information about you, or to discuss your case with another physician., your signature is required.

Patient / Responsible Party's Signature Date (Required)

MEDICARE PATIENTS / HMSA SIXTY-FIVE C PLUS PATIENTS

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Allison Shigezawa MD, for any services furnished to me by their physician(s). I authorize any medical information about me to be released to the Health Care Financing Administration and its agents to determine my benefits for services.

Patient / Responsible Party's Signature Date (Required)

OTHER INSURANCE (HMSA,CHAMPUS,QHCP.VSP,UHA,UHC)

I request that payment of authorized benefits be made either to me or on my behalf to Allison Shigezawa MD, for any services furnished to me by their physician(s). I authorize any medical information about me to be released to CHAMPUS or other carriers of insurance pertaining to my coverage, and its agents to determine my benefits for services. I understand that I will be billed for any deductibles, applicable co-payments, and any services performed by Allison Shigezawa MD or her staff that is considered necessary but is not payable by my insurance.

Patient / Responsible Party's Signature Date (Required)

NO INSURANCE

In order to keep office overhead and therefore patient charges reasonable, we prefer not to send statements . We would appreciate it if you clear you account at the time of service. All private insurance forms brought in by you will be filled out and sent upon full payment of all charges incurred for your reimbursement. We file all insurance, that we participate with, for you.

Patient / Responsible Party's Signature Date (Required)

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name _____

Age _____ Date of Birth _____

Reason for visit _____

Obstetric history: Please list all pregnancies including miscarriages, terminations, and type of delivery (i.e. vaginal or Cesarean)

Year	Early/Late/on time	Type of delivery	Sex	Weight Complications	Name

Date of last Menstrual period _____Normal (yes)___No___Days of bleeding _____

How many days from first day of Menses to first day of next Menses _____

Age of first Menses _____

Date of last Pap Smear _____ Done by? _____

Date of last Mammogram _____ Done by?

Type of Contraception use presently:

Condom usage_____Oral Contraceptive (Name)_____Other _____

MEDICAL HISTORY
Previous Medication
Current Medication
Major illness/conditions
Major surgery/procedures
Year of last cholesterol check and results (normal?)
Allergy to medicines and reactions

FAMILY HISTORY	
Arthritis	
Cancer	
Diabetes	
Heart attacks	
High blood pressure	
Kidney disease	
Lupus	
Stroke	
Thyroid disease	
Tuberculosis	
Other	

PERSONAL HISTORY	
Do you drink alcohol? If yes, how much?	
Do you smoke? If yes, how many packs a day?	
Have you ever had a blood transfusion?	
Have you ever been in intimate contact with a person who had a sexually transmitted disease?	
Occupation	