Form 1A **Wayne H. Fujita M.D., Inc**.

2023 Adult Registration Form

Referring Doctor: ______________________ DATE:

Patients Primary Care Doctor: __________________________

Patients Name: _________________________ Sex __ Birthdate: _____

Last Name First Name MI

SOCIAL SECURITY NUMBER _____-_____-_____

Address: ____

Number Street Apt # City ZIP Code

Home Phone: ________ Cell Phone: _____________ Work Phone: ________

Employed By: _________________ Occupation: ___________________

Ethnicity/Race________________ Language ____________/& or English

Spouse: _____________________ Sex ____ **Birthdate** ________________

Last Name First Name MI

Address: ____

Number Street Apt # City ZIP CODE

Home Phone: ________ Cell Phone: _________ Work Phone: _______

Employed By: _________________ Occupation: ___________________

Primary Ins Co: ______________ **Secondary Ins Co: __________**

Subscribers Name: _______________ Subscribers Name: ______________

Birthdate: ___________________ Birthdate: _____________________

Circle: Self / Spouse Circle: Self / Spouse

Membership ID# _______________ Membership ID # _______________

Grp # ________ Coverage Code _____ Grp # _______ Coverage Code __

I certify that the above name, address, phone numbers and insurance information is correct. I understand that I will be held financially responsible and that my account will immediately become collectable in full if the insurance information is incorrect. *I understand that I am responsible for amounts not covered by insurance and that there will be a $27.50 charge for any returned checks and a $27.50 charge if my delinquent account (over 3 months old) is sent to collection.*

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of April 14, 2003. Also I hereby authorize Dr. Wayne H. Fujita to release any medical and / or other information as needed by my insurance company, in order that any medical claim for services rendered may be processed. I further authorize my insurance company to pay any medical benefits due me for same, directly to Dr. Wayne Fujita, on my behalf. I also authorize Dr. Fujita’s staff to leave messages about appointment reminders at my home, or on my answering machine. I also authorize to receive mailed updates on any new products or procedures offered at Dr. Wayne Fujita’s office.

_______________________________ __________________

Signature of Patient/Patient Representative Date