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

2023 CHILD Registration Form

Referring Doctor: _____ DATE:

Childs Pediatrician or Primary Care Doctor: _____

PATIENTS NAME : _____ ___ _____

Last Name First MI SEX Birthdate

Address: _____

Number Street Apt # City ZIP CODE

Responsible Party: _____ Sex ____ **Birthdate** _____

Father/Mother/ Step parent Last Name First Name MI

Address: circle: same or/ _____

Number Street Apt # City ZIP CODE

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employed By: _____ Occupation: _____

Other Parent Name:_____ Sex ____ **Birthdate** _____

Father/Mother/ Step parent Last Name First Name MI

Address: circle: same or/ _____

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 : Father / Mother / Step parent Circle : Father / Mother / Step parent

Ins Membership ID# _____ Ins 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 month 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 Parent or Responsible Party: _____ Date _____