Form 1A

Wayne H. Fujita M.D., Inc.
2026 Adult Registration Form

Referring Doctor: _____ DATE: _____

Patients Primary Care Doctor: _____

PATIENTS NAME: Last Name: _____ First Name: _____MI: ___

Sex: _____ Birthdate: _____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: Last Name: _____ First Name: _____ MI: _____

Sex: _____ Birthdate: _____ Address: Number: _____ Street: _____

Apt #: _____ City: _____ZIP Code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Employed By: _____ Occupation: _____

Primary Ins Co: _____ Subscribers Name: _____

Membership ID#: _____ Grp #: _____ Coverage Code: _____

Secondary Ins Co: _____ Subscribers Name: _____

Membership ID#: _____ 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: _____