PATIENT REGISTRATION

PATIENT'S NAME: ____
Last Name First name Middle Initial

ADDRESS: ____

CITY: ______________________ STATE:____________ ZIP: ______________

SEX: F M AGE: _______ DOB: _____________SSN: ______________________

DRIV LIC: _______ MARITAL STATUS: _________ SPOUSE'S NAME: _______________

May we leave detailed health information on a telephone voicemail if needed □Yes □No
If NO, office personnel will limit voicemail transactions to a request for call back and/or appointment reminders

HOME PHONE: ______________________ CELL PHONE: ______________________

E-MAIL ADDRESS: ____

EMPLOYER: ____

OCUPATION: __________________ WORK PHONE: _________________ EXT: _____

ADDRESS: ____________________ CITY: _________ STATE: ________ ZIP: _____

EMERGENCY CONTACT: ____________________ RELATIONSHIP: ________________

HOME PHONE: __________________________ CELL PHONE: _________________

INSURANCE CO: ______________________________ PHONE: _________________

NAME OF INSURED: _______________________ RELATIONSHIP: ________________

I the undersigned, have read the above and realize that all medical charges insured by or my dependents for services rendered by Katharine C. Nitta, M.D. are my financial responsibility. All court fees, attorney's fees, or other fees necessary to collect this amount are payable by me. I authorize assignment payment to Katharine C. Nitta, M.D. for medical benefits due. I hereby agree to pay all charges that are not covered by my insurance.

Signature: ____

Date: __________