PATIENT REGISTRATION FORM FOR INTERNAL MEDICINE ASSOCIATES, S.C.

Date Completed: / / . Primary M.D.: ___ Dr. Hoshizaki ___ Dr. Einfalt ___ Dr. Thayu

I. PATIENT INFORMATION: Please print your full legal name (no nicknames). Specify Jr., Sr., I, II, III, if applicable.

PATIENT NAME: _____ _____ _____
LAST FIRST MIDDLE

_____/_____/_____ __ M __ F __S __M __W __D _____-_____-_____
DATE OF BIRTH SEX MARITAL STATUS SOCIAL SECURITY NUMBER

_____ _____ _____ _____
PATIENT'S ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ ; EXTENSION: (_____)_____
HOME PHONE WORK PHONE CELL PHONE

_____ _____
PATIENT'S EMPLOYER ADDRESS

II. INSURANCE INFORMATION:

1._____ ; _____ ; _____
PRIMARY INSURANCE COMPANY POLICY NUMBER GROUP OR CERTIFICATE #

Coverage Type: ___ Group Policy; ___ Individual Policy; ___ Medicare; Other: _____

2._____ (_____)_____
PRIMARY INSURANCE CLAIM FILING ADDRESS - SEE INSURANCE CARD INSURER'S TELEPHONE NUMBER

3._____; _____-_____-_____; _____/_____/_____
PRIMARY INSURANCE - POLICY HOLDER'S NAME SOCIAL SECURITY NUMBER DATE OF BIRTH

4. Primary Insured's Employer: _____

1._____; _____; _____
SECONDARY INSURANCE COMPANY, IF APPLICABLE POLICY NUMBER GROUP OR CERTIFICATE #

Coverage Type: ___ Supplemental; ___ Group Policy; ___ Individual Policy; ___ Medicare.

2._____ (_____)_____
SECONDARY INSURANCE CLAIM FILING ADDRESS - SEE INSURANCE CARD INSURER'S TELEPHONE NUMBER

3._____; _____-_____-_____; _____/_____/_____
SECONDARY INSURANCE: POLICY HOLDER'S NAME SOCIAL SECURITY NUMBER DATE OF BIRTH

4. Secondary Insured's Employer: _____

III. Responsibility For Charges: ___ Self ___ Spouse Other:_____ _____
NAME RELATIONSHIP

IV. PAYMENT OF BENEFITS: I understand that all Medicare and participating Managed Care Plan claims for services rendered are filed directly by Internal Medicine Associates, S.C. I, therefore, authorize release of any medical information requested by my health insurance carrier pertaining to these claims. I further authorize payment of benefits directly to my physician, and this authorization is valid until canceled in writing or replaced by a signed authorization of a later date. I also acknowledge that all co-pays are due at the time of service, and that I am legally responsible for all charges not covered by my insurer.

_____ _____/_____/_____
PATIENT'S OR GUARANTOR'S SIGNATURE DATE ACKNOWLEDGED

RELATIONSHIP TO PATIENT: _____