



Nihon Clinic
日本クリニック

PATIENT INFORMATION 外来診察申込書

DATE: _____

紹介者: _____

REFERRED BY: _____

患者氏名					FIRST NAME:									
LAST NAME:														
誕生日	月	日	年	年齢	性別	男	女	独身	既婚	ソーシャルセキュリティ				
D.O.B.	/	/		AGE:	SEX:	M	F	<input type="checkbox"/> Single	<input type="checkbox"/> Married	SSN:				
世帯主名 <input type="checkbox"/> 同上 (same as above)					勤務先									
GUARANTOR:					EMPLOYER:									
自宅住所					勤務先住所									
ADD:					ADD:									
CITY:			ST:		ZIP:			CITY:			ST:		ZIP:	
自宅電話					勤務先電話									
TEL: ()					TEL: ()									
携帯電話					ファクシミリ									
CELL: ()					FAX: ()									
E-MAIL:					E-MAIL:									

INSURANCE INFORMATION 医療保険

保険会社					POLICY#:					GROUP#:									
COMPANY:																			
保険会社住所					電話														
COMPANY ADD:					TEL:														
被保険者氏名 <input type="checkbox"/> 同上 (same as above)					FIRST NAME:					ソーシャルセキュリティ									
LAST NAME:										SSN:									
誕生日	月	日	年	年齢	性別	男	女	被保険者との関係	自身	夫婦	子供	他							
D.O.B.	/	/		AGE:	SEX:	M	F	RELATION TO SUBSCRIBER:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER							
被保険者住所 <input type="checkbox"/> 同上 (same as above)					SUBSCRIBER ADD:														
					CITY:					ST:					ZIP:				

EMERGENCY CONTACT 緊急時の連絡先

緊急時連絡先					患者との関係					自身					夫婦					子供					他				
CONTACT PERSON:					RELATION TO PATIENT:					<input type="checkbox"/> SELF					<input type="checkbox"/> SPOUSE					<input type="checkbox"/> CHILD					<input type="checkbox"/> OTHER				
連絡者住所					自宅電話					HOME TEL: ()																			
HOME ADD:					電話番号					()																			
日本での連絡先住所:																													

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize to release any information in the course of my treatment or examination to my insurance carrier.
I hereby authorize payment to Physician of Benefits due me for service rendered. I understand that I am responsible for charges not covered by this authorization.

SIGNED: _____

DATE: _____

NIHON MEDICAL CLINIC S.C.

Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that Nihon Clinic has a Privacy Policy in place in accordance with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

As a patient of Nihon Clinic, I understand and acknowledge the following:

1. Nihon Clinic has a privacy policy in effect in their offices.
2. Nihon Clinic has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version in a binder that resides in the waiting room or similar common area with patient access.
3. Nihon Clinic has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Nihon Clinic, and have read, understand and acknowledge the form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ **No, I DO NOT** want a copy but I acknowledge the Privacy Policy exists.

_____ **Yes, I Do** want a copy of the Privacy Policy

Patient Name

Date

Signature by Guarantor