



PATIENT INFORMATION

Patient Name: _____ Birthdate: ____ / ____ / ____ Sex: M F
Address: _____
Street City State Zip Code
Phone (H): _____ Phone (B): _____ SS Number _____
Relationship to Responsible Party: _____ Marital Status M S D W
Employment Status: F/T P/T Student Retired E-Mail Address: _____

RESPONSIBLE PARTY:

Name: _____
Last First Middle
Address: _____
Street
City State Zip Code
Phone (H): _____ Phone (W): _____
Referring Physician: _____
Employer: _____
Address: _____
Street
City State Zip Code
SSN: _____ Sex: M F

EMERGENCY CONTACT:

Name: _____
Phone (H): _____ Phone (W): _____
Relationship: _____

INSURANCE INFORMATION:

Primary Insurance Policy Number
Group Number Coverage Code Effective Date
Expiration Date
Subscriber Name:
Last First Middle
Birthdate: ____ / ____ / ____ Sex: M F
Secondary Insurance Policy Number
Group Number Coverage Code Effective Date
Expiration Date
Subscriber Name:
Last First Middle
Birthdate: ____ / ____ / ____ Sex: M F
Employer: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY

I hereby authorize Dr. Hugo Higa or his representative to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Dr. Hugo Higa. The assignment will remain in effect unless revoked by me in writing. A photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I will be assessed a \$15.00 charge for each check returned due to insufficient funds. I further understand that a 1 % finance charge (12% annually) maybe added to any balance over 90 days. In the event of default, I (we) promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect the collection of this note. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____

Date: _____