Date:_____

Curtis Takemoto-Gentile, MD & Krishanna Takemoto-Gentile, MD

Registration Form

Patient Information

Last Name:	First Name:	Middle Initial:

Preferred Name/Nickname:	Date of Birth: / /	Age:	Social Security Number:

Birth Sex: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Genderqueer ☐ Choose not to disclose ☐ Other, please specify: _____

Physical Address (Street, City, State, Zip Code):

Mailing Address (Street, City, State, Zip Code), *if different from Physical Address*:

Primary Phone:	Secondary Phone:	May we leave voicemail: ☐ Yes ☐ No	Email:

Marital Status: ☐ Divorced ☐ Life Partner ☐ Widowed ☐ Married ☐ Single ☐ Legally Separated

Primary Language:

Race: ☐ American Indian/ Alaskan Native ☐ Black/ African American ☐ Native Hawaiian/ Pacific Islander ☐ Other: _____ ☐ Asian ☐ Decline to Specify ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify

Do you have an Advanced Directive? *(If yes, please provide our office with a copy.)* ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Reserves

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

Occupation:	Employer Name:

Employer Address (Street, City, State, Zip Code):	Employer Phone:

Emergency Contact

Name of Contact:	Primary Phone:	Secondary Phone:

Address of Contact (Street, City, State, Zip Code):	Relationship to Patient:

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last):	Date of Birth: / /	Phone:

Address (Street, City, State, Zip Code), *if different from the patient above*:

Patient Name:_____

Medical Insurance (please present your Insurance Card(s) and ID to receptionist)

PRIMARY Insurance Company Name:	Member/Subscriber ID:		Group Number:
Subscriber Name (as it appears on card):	Subscriber Birth Date: / /	Subscriber Phone:	Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent

SECONDARY Insurance Company Name:	Member/Subscriber ID:		Group Number:
Subscriber Name (as it appears on card):	Subscriber Birth Date: / /	Subscriber Phone:	Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent

Information Authorization

Do you authorize the release of your medical records to anyone other than yourself? This includes people that may call our office to schedule appointments, refill medications, or ask any other medical questions on your behalf. (***Signature needed)

☐**YES** ☐**NO**

*****Signature to Authorize Access:** _____ **Date:**_____

If yes, please list these person(s) below:

Name:	Phone:	Relationship to Patient:
Name:	Phone:	Relationship to Patient:
Name:	Phone:	Relationship to Patient:

Patient Consent

1. **I agree to be contacted via email or SMS with information related to my visit, like: patient portal invitation, appointment or checkup reminder, health tips, or new services that relate to me or my family.**

2. **I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.**

3. **I have read and/or received a copy of the Notice of the Use and Disclosures of Protected Health Information that is available in the office. I hereby acknowledge that I may receive from Curtis Takemoto-Gentile, MD, Inc, a copy of the Notice (HIPAA privacy policy).** *(please see our receptionist for a copy or visit our website, www.doctorctg.com)*

4. **I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.**

Patient or Guardian Signature:_____ **Date:**_____

Print Name of Guardian (if applicable)**:**_____