GREG K. SAKAMOTO, M.D.
DERMATOLOGY

QUEENS PHYSICIANS OFFICE BLDG III
550 S BERETANIA STREET, STE 603
HONOLULU, HI 96813
PH: (808) 447-7454 FAX: (808) 447-7456
WWW.SAKAMOTODERMATOLOGY.COM

PATIENT REGISTRATION FORM

Patient Name: _____ **Date of Birth:** _____ **Gender:** □ M □ F
Last First MI

Marital Status: _____**Social Security #:**_____ **Preferred Language:** □ English/ □ Other_____

Home Phone #: _____**Mobile Phone #:** _____ (circle preferred phone #)

Primary Address: _____**Apt#:** _____**City:** _____ **Zip:**_____

Secondary Address: _____**Apt#:** _____**City:** _____**Zip:**_____
(if applicable)

Emergency Contact: _____ _____ _____
Name Relationship Phone #

Email:_____**NOTE: Patient Portal Access is set up via email. A link to our patient portal is also found on our website: (www.sakamotodermatology.com)*

BILLING INFORMATION (if different from above):
NOTE: Patients under 18 must be accompanied by a parent/guardian, or have an "Authorization to Treat a Minor" form on file

Responsible Party Name: _____ **Date of Birth:** _____ **Gender:** □ M □ F

Relationship to Patient: **(circle one)** **Spouse / Parent / Other:**_____ **Email:**_____

Home Phone #: _____**Mobile Phone #:** _____ (circle preferred phone #)

Primary Address: _____**Apt#:** _____**City:** _____ **Zip:**_____

Secondary Address: _____**Apt#:** _____**City:** _____**Zip:**_____

INSURANCE INFORMATION: *In order for us to file a claim on your behalf, this section must be completed in its entirety, and a valid insurance card is required upon check-in.*

	1. PRIMARY	***2. SECONDARY***	***3. TERTIARY***
Insurance Company:	_____	_____	_____
Subscriber Name:	_____	_____	_____
Relationship to Patient:	□Self □Spouse □Parent □____	□Self □Spouse □Parent □____	□Self □Spouse □Parent □____
Subscriber Date of Birth:	_____	_____	_____
Subscriber Address:	_____	_____	_____
(Street, City, State, Zip)	_____	_____	_____
Subscriber ID #:	_____	_____	_____
Group Name/#:	_____	_____	_____

My signature below indicates that I have received, reviewed, and agree to the policies set forth on the forms titled: (1) *Financial and Office Policies*, and (2) *Notice of Privacy Practices*. I attest that this form is accurate and complete to the best of my knowledge. I hereby authorize the release of any medical information necessary to process claims pertinent to my care with Greg K. Sakamoto, MD and I authorize my insurance benefits to be paid directly to this practice and acknowledge that I am financially responsible for any unpaid balance.

x_____ _____
Responsible Party Signature Date