NY Midtown OB/GYN, PLLC

□ Yuzuru Anzai, M.D. □ Maria Teresa Benedetto-Anzai, M.D.

患者?入フォ?ム[Demographic Form]

□ Teresa Cheon, M.D. □ Spencer McClelland, M.D.

患者情□ [Patient Information]

氏名 [Name (Last, First, MI)]				日付 [Today's Date]
住所 [Street Address]		Apt. #		生年月日[Date of Birth (mm/dd/yyyy)]
市 [City]	州 [State]	?便番号[Zip]	年?[Age]	Email Address
?? 番号[Daytime Phone] ( )	携?番号[Cell Phone] ( )	?? [Occupation]		雇用者 [Employer]
Social Security #	婚姻?? [Marital Status] □独身[Single] □既婚[Married] □?婚[Divorced] □死?[Widowed] □?居[Separated]			

配偶者情□ [Spouse Info]

氏名 [Spouse/Partner's Name]	生年月日 [Spouse/Partner's DOB (mm/dd/yyyy)]
携?番号・Eメ?ルアドレス [Spouse/Partner's Phone Number + Email]	

□急□□□ [Emergency]

氏名 [Name]	患者との?柄 [Relationship to Patient]
日中の??番号 [Daytime Phone] ( )	夜中の??番号 [Evening Phone] ( )

保□情□ [Insurance Information] (Please provide ALL)

主要保?会社[PRIMARY Insurance Company]	契?番号[Policy #/Member #]	[Group #]	Copay $
被保?者に?する患者の?柄 [Relationship to Insured] □ 本人[Self] □配偶者[Spouse] □子供[Child] □その他[Other]_____		加入者の氏名（患者以外の?合) [Subscriber]	
加入者のSSN [Subscriber's Social Security #]	性? [Gender]	生年月日[Date of Birth]	
二次的保□会社[SECONDARY Insurance Company]	契?番号[Policy #/Member #]	[Group #]	Copay $
被保?者に?する患者の?柄 [Relationship to Insured] □ 本人[Self] □配偶者[Spouse] □子供[Child] □その他[Other]_____		加入者の氏名（患者以外の?合） [Subscriber]	
加入者のSSN [Subscriber's Social Security #]	性? [Gender]	生年月日[Date of Birth]	

□介者情□ [Referral Info]

?介医?の氏名 [Referring Physician's Name (if applicable)]	医?の??・ファックス番号[Physician Phone/Fax]
医?の住所 [Physician's Address]	

Assignment and Release

いかに署名することにより､私は､提供した情?は自分の??内で正しいことを?めます｡

Please read the following and sign below

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment check(s) directly to NY Midtown OBGYN for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorizaiton to Release Information

I hereby authorize NY Midtown OBGYN to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from NY Midtown OBGYN on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

患者の署名[Signature]:_____ 日付[Date]:_____