HILO OBSTETRICS & GYNECOLOGY– QUYEN TRAN, M.D.

PATIENT REGISTRATION FORM –Please fill out this form to register as a patient of Hilo Obstetrics & Gynecology. We cannot register you as a patient without this information. Please print clearly.

PATIENT INFORMATION

Name (Last, First, Initial) _____
Mailing address_____
Residence address_____
SSN_____ Birthdate_____
Email address_____ Marital Status_____
Occupation_____ Employer_____
Home phone_____ Work_____Cell_____
May we identify ourselves as your doctor's office?_____ is it okay to leave a message?_____

INSURANCE INFORMATION – A copy of your insurance card will be scanned into your chart

Primary insurance_____
Subscriber's name_____Relationship_____ DOB_____
Subscriber's ID #_____Group #_____Cov Code_____

Secondary insurance_____
Subscriber's name_____Relationship_____ DOB_____
Subscriber's ID #_____Group #_____Cov Code_____

RESPONSIBLE PARTY FOR PATIENT PAYMENTS

Name_____ Birthdate_____
Address_____ SSN_____

EMERGENCY CONTACTS

Name_____Relationship_____Phone_____
Name_____Relationship_____Phone_____

ADDITIONAL INFORMATION

Whom should we thank for referring you?_____
Who is your Primary Physician?_____
Primary Pharmacy?_____ Phone_____
If the patient is a child, who may authorize treatment for this child?_____
Relationship to patient/child_____Phone_____
Do you authorize release of your medical information to anyone besides your insurance carrier(s)?__
If yes, whom?_____

ASSIGNMENT, AUTHORIZATION AND RELEASE – By signing, you agree to the following

I hereby authorize Quyen Tran, M.D. to treat me or the family member listed as the patient as deemed necessary. I further authorize Hilo Obstetrics and Gynecology, LLC and/or its representative, to release all medical information including electronic medical records regarding my illness; past, present, and future care; and/or injury to my insurance carrier(s), any health care facility, and any other physician or physicians' group that would benefit my health care. I further authorize the release of billing information and dates of services to any collection agency or attorney retained by Hilo OB/GYN. I hereby assign all medical and/or surgical benefits, to which I am entitled, to Hilo OB/GYN. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization is as valid as the original. I understand that I am financially responsible for 1) all charges incurred, whether or not they are paid by my insurance; 2) payment of services in full if my insurance is terminated or I exceed my annual benefits; and 3) services not covered by my insurance, including telephone consultations. This office reserves the right to charge a late payment fee, a returned check fee, and/or a no-show fee. Should the account be referred for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts. I understand that failure to pay for services rendered will result in suspension or termination of services by Hilo OB/GYN.

Signature of patient_____ Date_____

(or parent or guardian if patient is a minor)