

Hiramoto & Boretz Orthopaedics

— Harlan Hiramoto, MD

— Robert Boretz, MD

PATIENT REGISTRATION INFORMATION

Name: _____
Last First Initial

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Birth date: _____ Soc Sec #: _____

Please check: Male Female Minor Single Married Long Term Partner Divorced Widowed Separated

Employer: _____ Occupation: _____

Business Address: _____

Work Phone: () _____ Cell Phone: () _____

Primary Care Doctor: _____ Who referred you to our office? _____

In case of emergency, who should we call? _____

PRIMARY INSURANCE

Insurance Policy Holder: _____
Last First Initial

Relationship to Patient: _____ Birth date: _____ Soc Sec #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Occupation: _____

Policy Holder Employer: _____

Business Address: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber ID #: _____ Group #: _____

Work Phone: () _____ Cell Phone: () _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insurance Policy Holder: _____
Last First Initial

Relationship to Patient: _____ Birth date: _____ Soc Sec #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Occupation: _____

Policy Holder Employer: _____

Business Address: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber ID #: _____ Group #: _____

Work Phone: () _____ Cell Phone: () _____

I hereby give consent to the above noted provider to examine & render treatment to me or my dependents. I also authorize payment directly to Hiramoto Orthopaedics & Sports Medicine, PA, or Robert Boretz, MD LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I also authorize the above noted doctor &/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Party

Date