### Raine Fukuda Urology, LLC

405 N. Kuakini St. Suite 1103, Honolulu, Hawaii 96817

Phone: (808) 521-8288 Fax: (808) 526-0069

# REGISTRATION FORM

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| **(PLEASE PRINT CLEARLY)** | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | |
| **Last name:** | | | | **First:** | | | | **Middle:** | | **❑ Male**  **❑ Female** | | | | **Marital status (circle one)** | | |
|  | | | | | | | | | | **Single / Mar / Div / Sep / Wid** | | |
| **Social security #:** | | | | | | | **Birth date:** | | | | | | **Email:** | | | |
|  | |  | | | | | **/ /** | | | | | |  | | | |
| **Street address:** | | | | | | | | | | | | | **Home phone :** | | | |
|  | | | | | | | | | | | | |  | | | |
| **City:** | | | | | **State:** | | **ZIP code:** | | | | | | **Mobile phone:** | | | |
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| **Occupation:** | | | **Employer:** | | | | | | | | | | **Work phone:** | | | |
|  | | |  | | | | | | | | | |  | | | |
| **Preferred Language:** | | | | | | | **Ethnicity:** | | | | | | **Primary Care Physician:** | | | |
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| EMERGENCY Contact | | | | | | | | | | | | | | | | |
| **In case of emergency, whom should we notify?** | | | | | | **Relationship to patient:** | | | | | **Home phone:** | | | | **Mobile phone:** | |
|  | | | | | |  | | | | |  | | | |  | |
| **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**  I hereby give my consent for Raine Fukuda Urology, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Policy provided by Raine Fukuda Urology, LLC describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Policy prior to signing this consent. Raine Fukuda Urology, LLC reserves the right to revise its Notice of Privacy Policy at any time. A revised Notice of Privacy Policy may be obtained by forwarding a written request to the office. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent  **I HAVE READ AND UNDERSTAND THE PATIENT FINANCIAL AGREEMENT**  The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Raine Fukuda Urology, LLC or insurance company to release any information required to process my claims.  If at any time you have any questions or concerns regarding our fees or policies, please feel free to contact at us at 521-8288. | | | | | | | | | | | | | | | | |
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|  | **Patient/Guardian signature** | | | | | | | |  | | | **Date** | | | |  |