



Nihon Clinic  
日本クリニック

PATIENT INFORMATION 外来診察申込書

DATE: \_\_\_\_\_

紹介者: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

患者氏名					FIRST NAME:									
LAST NAME:														
誕生日	月	日	年	年齢	性別	男	女	独身	既婚	ソーシャルセキュリティ				
D.O.B.	/	/		AGE:	SEX:	M	F	<input type="checkbox"/> Single	<input type="checkbox"/> Married	SSN:				
世帯主名 <input type="checkbox"/> 同上 (same as above)					勤務先									
GUARANTOR:					EMPLOYER:									
自宅住所					勤務先住所									
ADD:					ADD:									
CITY:			ST:		ZIP:			CITY:			ST:		ZIP:	
自宅電話					勤務先電話									
TEL: ( )					TEL: ( )									
携帯電話					ファクシミリ									
CELL: ( )					FAX: ( )									
E-MAIL:					E-MAIL:									

INSURANCE INFORMATION 医療保険

保険会社			POLICY#:			GROUP#:						
COMPANY:												
保険会社住所			電話									
COMPANY ADD:			TEL:									
被保険者氏名 <input type="checkbox"/> 同上 (same as above)			ソーシャルセキュリティ									
LAST NAME:			FIRST NAME:			SSN:						
誕生日	月	日	年	年齢	性別	男	女	被保険者との関係	自身	夫婦	子供	他
D.O.B.	/	/		AGE:	SEX:	M	F	RELATION TO SUBSCRIBER:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER
被保険者住所 <input type="checkbox"/> 同上 (same as above)			SUBSCRIBER ADD:									
			CITY:			ST:			ZIP:			

EMERGENCY CONTACT 緊急時の連絡先

緊急時連絡先		患者との関係		自身		夫婦		子供		他	
CONTACT PERSON:		RELATION TO PATIENT:		<input type="checkbox"/> SELF		<input type="checkbox"/> SPOUSE		<input type="checkbox"/> CHILD		<input type="checkbox"/> OTHER	
連絡者住所		自宅電話									
HOME ADD:		HOME TEL: ( )									
日本での連絡先住所:		電話番号									
		( )									

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize to release any information in the course of my treatment or examination to my insurance carrier.  
I hereby authorize payment to Physician of Benefits due me for service rendered. I understand that I am responsible for charges not covered by this authorization.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

*For office use only:*

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Date of Admission: \_\_\_\_\_

By signing this form, you acknowledge that Nihon Clinic has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The policy, which has been made available for my review, explains how your health information will be handled in various situations. You must sign this form on your first date of service with us after December 1, 2014.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

- ☐ I have reviewed Nihon Clinic's Privacy Notice.
- ☐ I understand that I am entitled to a copy of this Privacy Policy if I so choose.
- ☐ Nihon Clinic has given me the chance to discuss my concerns and questions about the privacy of my health information.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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To be completed by Nihon Clinic's staff if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

☐ Yes                      ☐ No

Please explain why the patient was unable to sign an acknowledgement form and Nihon Clinic's efforts in trying to obtain the patient's signature:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_