Chart #: **PATIENT DEMOGRAPHIC INFORMATION** Provider:

Please review and update, correct and complete your personal and confidential information in our computer system. (Please make all changes directly on this form)

PATIENT NAME: _______________________________________ **DATE OF BIRTH:** __________________

MAILING ADDRESS: ____________________________________ **ZIP:** ____________ **CITY:** ___________ **ST:** _____

PHYSICAL ADDRESS: ___________________________________**ZIP:** ____________ **CITY:** ___________ **ST:** _____

(We will need this information if medications are prescribed)

EMAIL ADDRESS: ____

(You will be enrolled in our Patient Portal where you can access your medical records and update your medical information)

HOME PHONE: _______________ **WORK PHONE:** _____________________ **CELL PHONE:** _________________

SSN: ___-____-_______ **MARITAL STATUS**: { }Single { }Married { } Divorced { } Widowed

EMPLOYER NAME: ______________________ **JOB TITLE**: ____________________________

PRIMARY CARE PHYSICIAN: _______________________________________

PLEASE CIRCLE ALL THAT APPLY:

RACE: American Indian/Native Alaskan Asian African or Black Native Hawaiian/Pacific Islander White

LANGUAGE: English Chinese Japanese Filipino Spanish **ETHNICITY**: Hispanic or Latino Non-Hispanic

RELEASE OF PROTECTED HEALTH INFORMATION: (Please list all the individuals that you are allowing us to share your medical information with. Ex: Spouse or Significant other, Primary Care Physician, Family Members, or Caregivers):

____

____

RESPONSIBLE PARTY INFORMATION

Parent/Legal Guardian Name: ____ **DOB:** _________________

ADDRESS: ____

CITY, STATE AND ZIP: ____

SSN: _____-_____-_____ **HOME PHONE:** ________________________ **CELL PHONE:** _______________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____________________________ **ID #:** ___________________

SUBSCRIBER NAME: ______________________ **RELATIONSHIP:** _______________ **INSURED DOB:** _________

SECONDARY INSURANCE COMPANY NAME: ____________________________ **ID #:** ___________________

SUBSCRIBER NAME: ______________________ **RELATIONSHIP:** _______________ **INSURED DOB:** _________

As the responsible party, I authorize payment of medical and surgical benefits to Peter A. Matsuura, M.D. I have read, understand and agree to Dr. Peter Matsuura's Patient Payment Policy. Charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility and I will pay for my portion directly to Peter A. Matsuura, M.D. at the time of service. I have received for review Dr. Matsuura's Notice of Privacy Practices for Protected Health Information.

Signed: ____ ***Date:*** ____________________