Midori Nishimura, M.D., IBCLC
Family Medicine and Lactation

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Patient Registration Form

Last Name: ____________________ **First Name:** ____________________ **Middle Name:** _____________

Date of Birth: ___________________ **Sex assigned at birth:** □ M □ F □ Other

Gender Identity: □ M □ F □ Transgender Male □ Transgender Female □ Other

Address: ______________________________ **City:** _________________________ **Zip Code:** ___________

Cell Phone: __________________ **Work Phone:** _________________ (**Home Phone** ________________)

Emergency Contact Name: _______________________________ **Relation to patient:** __________________

Contact Phone #: _________________________________

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Other □ Employed □ Student

Employer: ____ **Occupation:** ___________________________

If Patient is a Minor Child:

Mother's Name: _____________________________ **Father's Name:** ______________________________

Child lives with: □ Mother □ Father □ Both □ Other ( )

Please provide your e-mail address if you are interested in the secure patient portal communication.
E-mail: _____________________________________

Insurance Information

□ **Self-pay**

□ **Primary Insurance Carrier:** ____________________________________

Name of Subscriber: ____ **Date of Birth:** __________________

ID # or SSN#: _________________________ **Group #:** __________________ **Effective Date:** ____________

Relation to Patient: □ Self □ Spouse □ Child

□ **Secondary Insurance Carrier:** _________________________________

Name of Subscriber: __________________________________ **Date of Birth:** __________________

Please Provide Your Insurance Card

I understand my signature requests that payment be made to ***Midori Nishimura, M.D., IBCLC, Family Medicine and Lactation*** and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: ______________________________________ Date: ______________