600 S. San Vicente Los Angeles California 90048
Tel: (310) 926-1793 Fax: (424) 270-1313

REGISTRATION FORM

(Please Print)

Today's Date:___________________________

PATIENT INFORMATION

Patient's Last Name____ First__________________________________ Middle___________ □Ms. □Miss.□Mr. □Mrs.

Date of Birth_______________ Marital Status (circle one) Single/Mar/ Div/Sep/Wid

Is this your legal name? □ Yes □ No If No, what is your Legal Name?____ □Ms. □Miss.□Mr. □Mrs.

Street Address:____

City:____ State:____________ Zip:____________Home Phone ( )_____________________________________

E-Mail address: ____

Occupation:____ Cell Phone ( )____

Employer:____ Work Phone ( )____

INSURANCE INFORMATION

Person responsible for bill: □ Self □ Insurance □ Other Birth date: / / Address If different:_______________________________________

Name Of Primary Insurance:____

Subscriber's Name:_______________________________________ Subscriber's SSN___________________________ Birth Date___________________________

Group Number____________________________________ Policy Number_____________________________________ Co-Pay $__________________________

Patients relationship to subscriber □ Self □Spouse □Child □Other

Name of Secondary Insurance(if applicable):_______________________________ Subscriber's name:________________________ Group no:________________

Policy:____

IN CASE OF EMERGENCY

Name:_______________________________ Relationship:________________________________ Phone( )________________Cell( )__________________

The Information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/Apex Multi specialty Medical Group. I understand that I am financially responsible for any balance. I also authorize the physician/ Apex Multi-specialty Medical Group or insurance company to release any information required to process claims.

Patient/Guardian signature:____**Date:**________________

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WOUND TREATMENT CONSENT FORM

I, (Patient)__________________________or_______________________________ as Patient Guardian, hereby authorize Dr. Kazu Suzuki provides me with medically necessary wound care treatment and diagnostic tests; including examinations, vascular tests, medications, sharp debridement and other services. I understand that this Consent Form will be valid and remaining in effect, from the date of signature, as long as Patient receives care, treatment and services from APEX Multispecialty Medical Group and Dr. Suzuki.

Wound Care Services: Wound care treatment may include, but not limited to: sharp debridement of wounds/calluses/nails, dressing changes, biopsies, skin grafts, injections, and compression bandage application.

Risks/Side Effects: may include, but not limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood or surrounding nerves, bleeding, allergic reaction to medications, removal of healthy tissue, prolonged healing or failure to heal.

Pictures: Patient understands and consents to images of all patients' wounds with their surrounding anatomic features. Patient agrees that their referring physician or other treating physicians may receive communications, including these images, regarding the patient's treatment plan and results. The images are considered part of the medical record and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information.

Financial Responsibility: Patient understands that regardless of their assigned insurance benefits, Patient is responsible for any amount not covered by insurance and authorizes medical information about Patient to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

BY SIGNATURE, I ACKNOWLEDGE THAT I HAVE READ THIS FORM IN ITS ENTIRETY, THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTION CONCERNING THE TREATMENT AND/OR PROCEDURE(S). I AGREE TO ITS PROVISIONS AND CONSENT TO THE TREATMENT OR PROCEDURE(S) PROPOSED.

Patient/Guardian Signature: ____ Date: ______

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PATIENT CONTACT INFORMATION

Please indicate the telephone number(s) that we can reach you and how you would most like to be contacted. This will help ensure that you receive all results or communication from us in the most efficient, appropriate and timely, manner.

(Please mark the appropriate boxes and fill- out all that apply)

• Home Phone Number

______ OK, to leave message with detailed information

______ Leave message with call back number only.

•Cell Phone

______ OK, to leave message with detailed information.

______ Leave message with call back number only.

•Work Phone

______ OK, to leave a message with detailed information.

______ Leave message with call back number only.

•Other Phone

______ OK, to leave message with detailed information.

______ Leave message with call back number only.

I hereby consent to release of my Protected Health Information to the following individuals. I understand this authorization will be effective until which time it is revoked.

Name:	Relationship:
1.____________________________________	____
2.____________________________________	____

____ ___________________________________

Patient Signature Date

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Patient Name: ____

Emergency Contact Person Name:______________________________ **Tel:**______________________

Pharmacy Name:____ **Tel:**_____________________

Allergies

TYPE	Yes	NO	List		Type of Reaction
Medication					
FOOD					
Latex Products					

LIST OF PATIENTS CURRENT MEDICATION :

	NAME OF MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				

Patient Signature___________________________________ **Date**________________________________