Earle Oki, MD
A Professional Corporation

Patient Name _____ _____ _____ Date of Birth _____ Sex Female
(Last) (First) (Middle)

◯ Single ◯ Married ◯ Separated ◯ Divorced Social Security Number _____

Address _____ _____ Nevada _____ Home Phone _____
(Number & Street) (City) (State) (ZIP) Mobile Phone _____

Patient's Employer _____ Work Phone _____
(Name & Address)

Parent or Spouse Name _____ Date of Birth _____

Parent or Spouse Employer _____
(Name & Address)

Parent or Spouse Social Security Number _____ Home Phone _____
Work Phone _____
Mobile Phone _____

Person whom we may contact in event of emergency

Name _____ _____ _____
(Last) (First) (Middle)

Address _____ _____ Nevada _____ Home Phone _____
(Number & Street) (City) (State) (ZIP) Mobile Phone _____

Are you allergic to any medication or latex? ◯ Yes ◯ No ◯ Don't Know

If Yes, enter the medication(s) here _____

I plan to make payment of my medical expenses as follows (check one or more):

☐ Cash ☐ Check ☐ Other _____

Insurance Information - Self

Subscriber's Name

Name of Insurance Plan

Effective Date Group #

Insurance Information - Spouse

Subscriber's Name

Name of Insurance Plan

Effective Date Group #

Do you plan to apply for Medicaid/MediCal? Yes ◯ No ◯

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements from RMC, promptly upon presentment thereof unless credit arrangements are agreed upon in writing prior to treatment. Charges shown by RMC statements are agreed to be correct and reasonable unless RMC is notified in writing within thirty days of the billing date. In the event legal action or collection should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fee, collection costs, or other such costs as court orders.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to RMC where applicable, but without RMC assuming responsibility for the collection thereof. I understand I must notify RMC of any changes of my address and/or telephone number.

Signature _____ Date _____