Transfusion Medicine Associates • **Office** 650.347.9200 • **Fax** 650.347.9205 • **Toll Free** 877.393.5700
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Dr. Thomas G. Hirose, M.D.
Medical Director

PATIENT REGISTRATION 2008

Please Print Clearly

Please *FAX* TO: 310.373.0600

TODAY'S DATE			
PATIENT NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	
ADDRESS	CITY	STATE	ZIP CODE
AREA CODE-TELEPHONE #	SEX ☐ M ☐ F	SS #	
OCCUPATION	MARITAL STATUS	DRIVER'S LICENSE #	
EMPLOYER	EMPLOYER TELEPHONE #		
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
REFERRING PHYSICIAN			
GUARANTOR/RESPONSIBLE PARTY			

PRIMARY INSURANCE – PROVIDE COPY OF INSURANCE CARD

SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT)	RELATION	DATE OF BIRTH	
NAME OF INSURANCE COMPANY	GROUP NAME OR ID #		
BILLING ADDRESS	CITY	STATE	ZIP CODE
MEDICARE #	MEDICAL #	SS #	

SECONDARY INSURANCE – PROVIDE COPY OF INSURANCE CARD

SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT)	RELATION	DATE OF BIRTH	
NAME OF INSURANCE COMPANY	GROUP NAME OR ID #		
BILLING ADDRESS	CITY	STATE	ZIP CODE
MEDICARE #	MEDICAL #	SS #	

I request that payment of authorized insurance benefits be made to me or on my behalf to Thomas G. Hirose, M.D. dba. Transfusion Medicine Associates for any services furnished me. I authorize holder of medical information about me to release to Transfusion Medicine Associates, Kaneka Pharma America, Healthcare Reimbursement Services, or the named insurance companies listed above and its agents any information needed to determine these benefits or the benefits payable for related services.

DATE	INSURED OR AUTHORIZED SIGNATURE

I understand my signature requests that payment be made and authorizes the release of medical information to pay the claim.

DATE	INSURED OR AUTHORIZED SIGNATURE