

# UROLOGY SPECIALISTS / USC AMBULATORY SURGICAL CENTER

## Patient Registration Form

GW # \_\_\_\_\_

Date \_\_\_\_\_

**Patient Information**

SD  MN  IA

Patient's Full Name			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone ( )	Cell Phone ( )
Date of Birth	Age	Social Security #		Race	Marital Status
Mailing Address			City	State	Zip Code
Employer		Address			Phone Number ( )
Email Address		Would you like an invite to our patient portal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language	
Was the Injury Job Related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury	The Result of an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident
In Case of Emergency Notify					Phone Number ( )
Name of Nearest Friend/Relative not living with you					Phone Number ( )
Family Physician (to whom records will be sent)			Address		Phone Number ( )
Referring Physician (to whom records will be sent)			Address		Phone Number ( )

**Responsible Party Information** (if different from above)

Responsible Party's Full Name & relationship to patient		DOB	Social Security #	Phone Number ( )
Address		City	State	Zip Code
Employer	Address			Phone Number ( )

**Insurance Information - if a referral is needed, please obtain before your appointment**

Primary Insurance			Secondary Insurance		
Policy Holder Name & Date Of Birth			Policy Holder Name & Date Of Birth		
Policy I.D. No.	Group No.		Policy I.D. No.	Group No.	
Insurance Address			Insurance Address		
City	State		City	State	
Effective Date			Effective Date		

I request that payment of authorized Medicare benefits be made to Urology Specialists/USC Ambulatory Surgical Center. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Urology Specialists/USC Ambulatory Surgical Center, for any services furnished to me until further notice. I authorize any holder of information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents. I have received a copy of the HIPAA Privacy Policy.

**I authorize the release of any medical or other information necessary to process my claims. I also request payment to be made to the party who accepts assignment. I understand that it is my responsibility to pay for all charges for the services incurred.**

Signature \_\_\_\_\_

Date \_\_\_\_\_