UROLOGY SPECIALISTS
Patient Registration Form

Chart # _____ MM # _____ Date _____

Patient Information

☐ SD ☐ MN ☐ IA

Patient's Full Name		Sex ☐ M ☐ F	Home Phone ( )	Cell Phone ( )
Date of Birth	Age	Social Security #	Race	Marital Status
Address		City	State	Zip Code
Employer		Address		Phone Number ( )
Email Address				
Was the Injury Job Related? ☐ Yes ☐ No		Date of Injury	The Result of an Accident? ☐ Yes ☐ 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		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. 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, 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**