Urology Specialists / USC Ambulatory Surgical Center

Patient Registration Form

PATIENT INFORMATION						
Last Name	First Name		Middle Name		Preferred Name	
Social Security #	Date of Birth	Age	Sex	Cell Phone	Home Phone	
Mailing Address				City	State	Zip Code
Marital Status	Race		Preferred Language		Email Address	
Primary Employer			Address		Phone Number	
Emergency Contact			Relationship to Patient		Phone Number	
Primary Physician (to whom records will be sent)			Address		Phone Number	

RESPONSIBLE PARTY INFORMATION (If Different Than Above)					
Full Name and Relationship to Patient			SSN#	Birth Date	Phone Number
Mailing Address		City	State	Zip Code	
Employer	Address			Phone Number	

PRIMARY INSURANCE			
Name of Insurance Company		Policy Holder Name & Date of Birth	
Insurance Address (where claims are to be sent)	City	State	Zip Code
Member ID #	Group Number	Effective Date	

SECONDARY INSURANCE			
Name of Insurance Company		Policy Holder Name & Date of Birth	
Insurance Address (where claims are to be sent)	City	State	Zip Code
Member ID #	Group Number	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 understand that a copy of the HIPAA Privacy Policy, Patient Rights pamphlet is available to me upon request.

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 OF PATIENT/GUARDIAN DATE