MRN: _____

Urology Specialists

Patient Registration, Insurance Information, and Confidential Communications

Patient Information			
Last Name	First Name	Middle Name	DOB
Preferred Phone #	Permission to leave a message? YES _____ NO_____	Sex	SSN
Mailing Address	City	State	Zip Code
Email Address	Marital Status	Race	Preferred Language
Primary Physician (to whom records will be sent), City, State, and Phone Number			
Patient lives in a nursing home, group home, or assisted living? YES _____ NO_____	Facility Name and Address:		
Primary Employer, Address, and Phone Number			

Primary Insurance	ID #	Group #	Secondary Insurance	ID #	Group #

Guarantor/Financially Responsible Party (if different than above)			
Name	Relationship	DOB	Phone Number
Address	City	State	Zip Code

Release of Information- I give Urology Specialists permission to communicate with the person(s) listed below. Please indicate medical information, financial information, or both. Only authorized information will be disclosed, except as permitted or required by law.

1. Name of contact	Relationship	Phone Number	**Appointment & Medical Information:** YES _____ NO_____ **Financial Information:** YES _____ NO_____
2. Name of contact	Relationship	Phone Number	**Appointment & Medical Information:** YES _____ NO_____ **Financial Information:** YES _____ NO_____

Emergency Contact- ONLY in the event of an emergency, Urology Specialists will contact the person(s) below. Only information addressing the emergency will be shared.

Name of contact	Relationship	Phone Number

Patient Signature: _____ Date: _____

If filled out by someone other than the patient:

Printed Name: _____ Relation to Patient: _____

Signature: _____ Date: _____