PATIENT REGISTRATION FORM

(PLEASE FILL OUT COMPLETELY)

PATIENT INFORMATION			
Last Name	First Name		MI
Social Security #	Address		Apt#
City	State		Zip
Primary Phone (Circle one: Home, Cell, Work)	Home Phone	Work	Cell
Date of Birth ☐Male ☐Female	Race American Indian-Alaska Native / Nat Hawaiian -Pacific Black-African American / White / Asian		Ethnicity Hispanic or Latino Not Hispanic or Latino
Are you married? ☐ Yes ☐ No	Spouse's Name		
Do you have a primary doctor? ☐ Yes ☐ No	If yes, First and Last Name of primary doctor:		Primary Care Phone Number
Did this doctor refer you? ☐ Yes ☐ No	If no, First and Last Name of referring doctor:		

INSURANCE INFORMATION		
Primary Insurance Company	**Contract Number**	**COPAY:**
Subscriber's First and Last Name	Date of Birth	Social Security#
Relationship to Patient	Employer	
Secondary Insurance Company	**Contract Number**	
Subscriber's First and Last Name	Date of Birth	Social Security#
Relationship to Patient	Employer	
Tertiary Insurance Company	**Contract Number**	
Subscriber's First and Last Name	Date of Birth	Social Security#
Relationship to Patient	Employer	

CONTACT INFORMATION		
Employer		
Emergency Contact	Relationship to Patient	Phone Number
Preferred Method of Communication For Appointment Confirmation (Circle one: Home Phone, Cell, Email, Text)		
PREFERRED PHARMACY	**PHARMACY PHONE #**	

I hereby authorize payment to UROLOGY Surgeons, P.C., for medical services rendered to me or others covered by my insurance policy. I authorize the release of such information as may be necessary for the billing office to file claim(s) for payment. I acknowledge financial responsibility for charges not covered under my insurance policy and any services not authorized by my Primary Care Physician. I authorize UROLOGY Surgeons to give me responsible and proper medical care by today's standards.

Patient's Signature: Date:____________________