

UROLOGY SPECIALISTS

Patient Registration Form

Chart # _____ MM # _____ 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
Address			City	State	Zip Code
Employer		Address			Phone Number () ()
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				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 & D.O.B.			Policy Holder Name & D.O.B.		
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 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 _____