

**PATIENT REGISTRATION INFORMATION - MUST BE UPDATED ANNUALLY**

\_\_\_Meyer      \_\_\_Hoppmann      \_\_\_Kaylor      \_\_\_Fallen      \_\_\_Spence

Date & Time of Appointment \_\_\_\_\_ Place \_\_\_ SD \_\_\_ DT \_\_\_ BV \_\_\_ SH

Physician or individual who referred you to this office: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status S M D W X U

Employment Status: \_\_\_1.FT \_\_\_2.PT \_\_\_3.Unemployed \_\_\_4.Self employed \_\_\_5.Retired \_\_\_6.Active Military \_\_\_9.Unknown

Student Status: \_\_\_Full Time Student \_\_\_Part Time Student \_\_\_Homemaker \_\_\_Male \_\_\_Female

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Patient can be reached between the hours of \_\_\_\_\_

**Medical Information**

X-rays? \_\_\_NO \_\_\_YES; at: \_\_\_\_\_ Reminded Re: Urine Specimen: \_\_\_YES \_\_\_NO

Purpose of Visit \_\_\_\_\_

**Insurance Information**

**WILL PATIENT OBTAIN REFERRAL? \_\_\_YES \_\_\_NO**

Primary Insurance: \_\_\_\_\_ Subscriber \_\_\_\_\_

Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_ Effective Date \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber \_\_\_\_\_

Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_ Effective Date \_\_\_\_\_

Third Insurance: \_\_\_\_\_ Subscriber \_\_\_\_\_

Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_ Effective Date \_\_\_\_\_

**Subscriber Information**

Subscriber Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_ Relation \_\_\_\_\_

**OTHER SIDE FOR MANDATORY AUTHORIZATIONS**

## MEDICARE PATIENTS PLEASE SIGN ALL THREE LINES

**RECORDS RELEASE - AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Urologic Physicians, P.A. to release any information acquired in the course of my examination or treatment to my insurance company and/or referring doctor. I hereby certify that the information I have provided is true and correct.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Patient, or Parent/Guardian if Minor)

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Urologic Physicians, P.A. of any insurance benefits payable to me for these services. I understand that I am financially responsible for the charges not covered by this authorization.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Insured Person)

**THIS MEDICARE AUTHORIZATION MUST BE SIGNED, IF PATIENT HAS MEDICARE; AUTHORIZATION IS MANDATORY TO ALLOW US TO FILE CHARGES WITH MEDICARE, ON THE PATIENT'S BEHALF:**

I request that payment of authorized Medicare benefits be made on my behalf to Urologic Physicians, P.A. for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those and all other charges for services rendered.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Patient's Signature)