



Allied Urology, P.S.C.

PATIENT REGISTRATION FORM

Patient Name _____ Date of birth _____ Age _____
(First) (Middle) (Last)

Address _____ SS# _____

City _____ State _____ ZIP _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Male Female Marital status: Single Married Widowed Divorced

Referring MD, address & phone _____

Family MD, address & phone _____

Emergency contact: Name _____ Phone# _____

Relationship to patient _____

Parent (if patient is a minor) _____ SS# _____ Date of birth _____

Patient's employer _____ Occupation _____

Employer's address _____

Spouse's name _____ Spouse's employer _____ Phone# _____

check if parent or guarantor address is same as patient address

Name of person responsible for bill _____

Address of person responsible for bill _____

Responsible party's SS# _____ Responsible party's date of birth _____

Responsible party's employer _____

INSURANCE (Please give your insurance card to the receptionist)

Primary _____ ID# _____ Group# _____

Secondary _____ ID# _____ Group# _____

Do you need a referral form to be seen today? _____ Do you have a co-pay? _____ Amount _____

Address of insurance company _____ Phone# _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release to my insurance company of any information acquired in the course of my examination or treatment. This information may be released now or in the future.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize and direct my insurance company to pay directly to Allied Urology, P.S.C. any medical and/or surgical benefits which would be payable to me for their services. I understand I am financially responsible for any charges not covered by my insurance policy.

AUTHORIZATION FOR MEDICAL TREATMENT: I authorize you to give me reasonable and proper medical care by today's standards.

Signature of Patient, Parent or Guardian (if patient is a minor) _____

Date _____