UROLOGY, LTD.

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PATIENT REGISTRATION FORM

General Information

Last Name: _____First:_____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home # _____ Work # _____ Cell # _____ Email _____

Date of Birth: _____ Age: _____ Sex: □ M □ F Social Security # _____

Employer: _____ Occupation: _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse/Partner Name: _____

Ethnicity (circle one) 1) Non-Hispanic 2) Hispanic 3) Refused to report

Primary Race (circle one) 1) White 2) Hispanic 3) Black or African American 4) Asian 5) American Indian 6) Native Hawaiian 7) Other Pacific Islander 8) Other Race 9) Unreported

Language (circle one) 1) English 2) Spanish 3) Indian-Hindi 4) Russian 5) Other

May we leave a personal message on your answering machine regarding your medical condition?
□ Yes □ No

Do we have permission to talk to another person (spouse, family member) about your medical condition or account information? □ Yes □ No

If yes, name of person(s):_____ Relation to you: _____

May we call you at work? □ Yes □ No May we call your cell phone? □ Yes □ No

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship of Emergency Contact: _____

Primary Insurance (Name of Insurance):_____

Subscriber Name: _____ DOB: _____ Social Security #_____

Employer: _____ ID#_____ Group #_____ Type (HMO, PPO)_____

Secondary Insurance (Name of Insurance):_____

Subscriber Name: _____ DOB: _____ Social Security #_____

Employer: _____ ID#_____ Group #_____ Type (HMO, PPO)_____

Pharmacy of Choice Name: _____ Address: _____ Phone: _____