The Urology Group, P.C.
Registration Form

Date: _____

Last Name _____ First Name _____

Date of Birth_____ Gender (circle): Male Female

Ethnicity (optional) please circle

Caucasian African American Hispanic/Latino Asian Other: _____

Preferred Language:_____

Street Address _____

City: _____ State_____ Zip_____

Social Security No.: _____

Patient's Employer _____

Marital Status: (circle) Married Single Divorced Widowed Separated Partner

Home Phone _____Cell Phone_____

Work Phone_____

*****May we leave messages/results for you on your voice mail/answering machine/email/text message*****

I am fully aware that a cell phone is not a secure and private line.

Home: Yes □ No □ **Work:** Yes □ No □ **Cell:** Yes □ No □ **Email:** Yes □ No □

Email Address:_____

* In emergency notify: (person not living with you)_____

Relationship_____

Phone_____

Pharmacy Name and Location _____

Pharmacy Phone#: _____

Mail Order Pharmacy_____

Care Team

Primary Care Provider:_____

Referring Physician_____

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Insurance or Responsible Party Information

PRIMARY INSURANCE _____

Effective Date_____ Group No.: _____

Subscriber No. or ID No._____

Subscriber Name:_____ DOB:_____

Soc. Sec. No.:_____

***PRIMARY INSURANCE'S PREFERRED LAB: _____

If you do not specify which lab is in network for your insurance, you are accepting responsibility for any and all services that may be sent out for analysis by your physician during your treatment plan.

SECONDARY INSURANCE_____

Effective Date:_____ Group No.:_____

Subscriber No. or ID No.:_____

Subscriber Name:_____ DOB:_____

Soc. Sec. No.:_____

***** Insurance Authorization: I hereby authorize The Urology Group PC to furnish information to insurance carriers concerning my illness and treatment. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

*****You will receive a statement upon receipt of your explanation of benefits (EOB) from your insurance company and will be required to make prompt payment in a timely fashion to avoid your account being turned over to an outside collections agency.

*****Letters / Form completion: At the discretion of the physician, letters and forms requiring medical review and physician signature are subject to a $20.00 fee per form.

*****Referrals: If your insurance company requires a referral to see a specialist, you are responsible for obtaining the referral. If the referral is not processed BEFORE your visit you will need to reschedule.

Signature of Patient or Responsible Party _____