

PATIENT REGISTRATION FORM

General Information

PATIENT NAME	<i>first</i>	<i>m.i.</i>	<i>last</i>	BIRTHDATE	AGE	GENDER
ADDRESS	<i>street</i>				<i>apt # / P.O. Box</i>	
<i>city</i>		<i>state</i>	<i>zip</i>	SOCIAL SECURITY NUMBER		

Contact Information

HOME PHONE	CELL PHONE	WORK PHONE
		<i>ext.</i>
PLACE OF EMPLOYMENT	SPOUSE/GUARDIAN NAME	
	<i>phone number</i>	
EMERGENCY CONTACT	<i>relationship</i>	<i>phone number</i>
REFERRING PHYSICIAN	<i>name</i>	<i>clinic</i>
		<i>phone number</i>
PRIMARY PHYSICIAN	<i>name</i>	<i>clinic</i>
		<i>phone number</i>

Insurance Information

PRIMARY INSURANCE		
ID / POLICY NUMBER	GROUP NUMBER	PLAN NUMBER
POLICY HOLDER	<i>name</i>	<i>birthdate</i>
		<i>social security number</i>

SECONDARY INSURANCE		
ID / POLICY NUMBER	GROUP NUMBER	PLAN NUMBER
POLICY HOLDER	<i>name</i>	<i>birthdate</i>
		<i>social security number</i>

I hereby authorize NORTH UROLOGY, LTD. to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS directly involved in my care, and for purposes of quality review and medical research studies. I authorize payment of any medical benefits to NORTH UROLOGY, LTD. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original.

SIGNATURE X: _____	DATE: _____
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CONSENT FOR OFFICE TREATMENT: I do hereby voluntarily consent to diagnostic procedures and medical treatment by members of NORTH UROLOGY, LTD. as necessary in my physician's professional judgement. I am aware that the practice of medicine is not an exact science and acknowledge no guarantees can be made about the result of such treatment.

SIGNATURE X: _____	DATE: _____
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MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to NORTH UROLOGY, LTD. for services furnished to myself by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me be released 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.

SIGNATURE X: _____	DATE: _____
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