Affiliated Urologist
Patient Registration Form

Date: _____ (Please Print & Complete in Full) **MRN#: _____**

PATIENT INFORMATION

Social Security #: _____-_____-_____

First Name: _____MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Age:_____ Sex: □ Male □ Female

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

Home Number: (____)_____-_____ Work Number: (____)_____-_____ Cell Number: (____)_____-_____

Race: □ ☐ African American □☐ Asian ☐ Caucasia □ ☐ Hispanic □ ☐ Native American □☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language:_____

If Patient is a child, lives with: □ Both Parents □ Mother □ Father□ Other: _____

Name of Person (With Whom Child Lives With): _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: _____-_____-_____

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female Relationship: _____

REFERRED BY:

Referring Physician: _____ Phone:(_____)_____-_____

PCP Physician: _____ Phone:(_____)_____-_____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

PHARMACY INFORMATION

Pharmacy Name: _____

(Name, Street Name & Phone Number, if known)

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize USSC and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: _____ DATE: _____