

UROLOGY HEALTH SPECIALISTS, LLC
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home # _____ Work # _____ Cell # _____

E-mail address: _____ Social Security # _____

DOB: _____ AGE: _____ SEX: ___ M ___ F

Spouse/Partner name: _____

If minor, name of Parent/Guardian: _____

Married _____ Single _____ Partnered _____ Widowed _____ Separated _____ Divorced _____

Employment Status: Currently not employed _____ Employed _____ Retired _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone # _____

Relationship of Emergency Contact: _____

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Local Pharmacy: _____ Phone # _____

Mail Order Pharmacy Plan Name: _____

Explain any special requirements for pharmacy plan – Quantity/Time interval

PLEASE SHOW INSURANCE CARD AT EACH VISIT.

**INSURANCE
PRIMARY**

Primary Subscriber Name: _____

Subscriber's Social Security Number: _____

DOB: _____ Employer: _____

I.D.# _____ Group # _____

**INSURANCE
SECONDARY**

Subscriber Name: _____

DOB: _____ Employer: _____

I.D.# _____ Group # _____

I hereby authorize Urology Health Specialists, LL to furnish my medical or other information to insurance carriers, their intermediaries, my attorney, or another physician's office. I understand that sensitive material from my medical history could be included.

I hereby assign to Urology Health Specialists, LLC all payments for medical services rendered to myself or my dependents. I understand I have financial responsibility for any amount whether or not paid by insurance.

A copy of this authorization is as valid as the original. This assignment will remain in effect until revoked by me in writing.

Signed: _____ Date: _____