

Pt. Acct.#: _____

Patient Registration

PATIENT: _____

Last

First

Middle Initial

Address: _____

Street

City

State

Zip Code

Out-of-State Address: _____

Street

City

State

Zip Code

Local Phone (____) _____ Alternate Phone (____) _____

Social Security #: _____ Date of Birth: ____ / ____ / ____ Age: _____ M F

Primary Ins. name: _____ ID# _____ Grp# _____

Pol. Sub.: _____ DOB: ____ / ____ / ____

Secondary Ins. name: _____ ID# _____ Grp# _____

Pol. Sub.: _____ DOB: ____ / ____ / ____

Employer: _____ (____) _____

Name

Address

Work Phone

Marital Status: S M D W Spouse: _____

Emergency Contact _____ (____) _____

Name *(Someone Not Living With You)*

Relationship

Phone #

Referring Physician: _____ Apptmt. Physician Name: _____

How did you FIND us?

Bradenton Herald Herald Tribune Ref. MD Friend/Family Web Search Phone Book: ATT Yellow Book Verizon

You will be asked:

- **If you do not have your insurance card with you**, payment of \$250 is requested upon **check-in**.
- **Upon checking-in**, to pay your insurance co-pay or,
- **Upon checking-out**, to pay your 20% co-insurance if **have NO Medigap Insurance**
- **Upon checking-out**, to pay any out-standing account balance.
- If you're having an **elective procedure** (i.e. vasectomy, etc.), to pay upon **checking-in**.

CASH, CHECK (in-state) or CREDIT CARD (Visa, M.C. or Am. Exp.) is accepted.

Please provide your current **insurance cards, driver's license & medication list** for copying when you check-in.

I authorize my **MEDICARE / COMMERCIAL INSURANCE** to make their payments directly to UROLOGY PARTNERS, PA for any services furnished to me. I will be responsible for paying any remaining balance after insurance pays Urology Partners.

X _____ Date: _____

Signature of Patient / Insured / Responsible party