Print Form

PATIENT REGISTRATION FORM

Patient Last Name: _____ First Name:_____

Patient Address: _____

City: _____ State: _____ Zip: _____

Patient Sex: M F Employed: Y N Employer Name: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Date of Birth: _____ Social Security #: _____

Marital Status: S M W D Number of Insurance Policies: _____

Referring Physician: _____

INSURANCE INFORMATION

Primary Insurance Name:_____

Address: _____

City, State, Zip: _____ Phone: _____

Group Name or #: _____ Effective Date: _____ ID#_____

Secondary Insurance Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Group Name or #: _____ Effective Date: _____ ID#_____

Tertiary Insurance Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Group Name or #: _____ Effective Date: _____ ID#_____

Spouse's Name (if applicable):_____ Spouse's DOB: _____

Nearest Living Relative / Friend not living with you: _____

Relationship to above: _____ Phone: _____

If necessary, did you obtain a referral for this visit? Y N

I authorize the release of medical information necessary to process claims for medical benefits. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health insurance to LAKEWOOD UROLOGY, LLC AND its subsidiaries and/or assignees. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I realize that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that I am financially responsible for all charges whether or not paid by my insurance including all reasonable costs, expenses, including court and attorney's fees incurred in pursuing collection of such charges.

Signature: _____ Date: _____