MIDLANTIC UROLOGY
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First: _____ M.I____

Address: _____

City: _____State:_____ Zip Code: _____

Home #_____Work #_____ Cell #_____

E-mail address: _____

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

Marital Status: _____Married _____Single _____Widowed _____Separated _____Divorced

Spouse/Partner name: _____ DOB: _____

If minor, name of Parent/Guardian: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone #_____

Relationship of Emergency Contact: _____

Referring Physician: _____ Phone #_____

Primary Care Physician: _____ Phone #_____

Local Pharmacy: _____ Phone #_____

Mail Order Pharmacy: _____

Pharmacy Benefit Plan Name (needed for prior authorizations): _____

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

Race: _____White _____Black/African American _____Asian _____Other

Ethnicity _____Hispanic _____Not of Spanish/Hispanic Origin

Primary Language _____

How did you learn about us: _____PCP/other physician _____Internet _____ OUR WEBSITE?

_____Family/Friend _____Insurance Company _____ other

PLEASE SHOW ID CARDS

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 MidLantic Urology 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 MidLantic Urology 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:_____