PATIENT REGISTRATION **PLEASE PRINT** Date:_____

Patient's Name: _____ Sex: _____

Address: _____ Date of Birth: _____

City: _____ St: ____ Zip: _____ Marital Status: **M S W D**

Home Phone: _____ Soc. Sec. #: _____

Cell Phone: _____ **Email**: _____

Employed by: _____ **REFERRING PHYSICIAN:**

Address: _____ _____

City: _____ St: ____ Zip: _____ **PRIMARY CARE PHYSICIAN:**

Business Phone: _____ _____

Occupation: _____

PREFERRED PHARMACY: _____
(name, location, phone number)

INSURANCE INFORMATION

Company #1 _____

Company #2 _____

Company #3 _____

Insurance Holder Information **(if other than the patient)**

Date of Birth: _____

Soc. Sec. #: _____

Employer: _____

Relationship to patient: _____

RESPONSIBLE PARTY Please complete section below, if someone other than the patient is responsible for the bill.

Name: _____

Address: _____

City: _____ St: ____ Zip: _____

Home Phone: _____

Occupation: _____

Please List Corrections Below:

_____

_____

_____

I authorize you to give me reasonable and proper medical care by today's standard.

I understand that I have the primary responsibility and obligation to pay the Physician for all services, irrespective of any contract or arrangement with any third party, such as an insurance company, employer, union or other party. The professional fees which I am responsible for are those established by the physician.

In addition, the undersigned also agree(s) to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney and court costs shall be paid for by the undersigned as allowed by the Court.

SIGNATURE OF RESPONSIBLE PARTY X _____ Date: _____

I hereby authorize the release of information acquired during examination or treatment to my insurance company. I authorize payment to Advanced Urology Associates.

SIGNATURE X _____ Date: _____