UROLOGY
SURGICAL CONSULTING, PC
Comprehensive Urological Care & Robotic Surgery

PATIENT REGISTRATION FORM

PATIENT

NAME- Last First Middle		DATE OF BIRTH	SEX □ MALE □ FEMALE □ OTHER-MEDICAL CONDITION □ OTHER-UNKNOWN
STREET ADDRESS	MAILING ADDRESS (PO BOX)		TELEPHONE HOME_____ WORK _____ CELL _____
CITY STATE ZIP CODE	E-MAIL (Required for Patient Portal)		
EMPLOYER	LENGTH OF EMPLOYMENT	EMPLOYMENT STATUS □ Full Time □ Part Time □ Self Employed □ Unemployed □ Retired □ Active Duty	
SOCIAL SECURITY # - -	PRIMARY LANGUAGE	STUDENT STATUS □ Full Time □ Part Time □ Not Student	MARITAL STATUS □ Single □ Divorced □ Married □ Separated □ Widowed
RACE □ American Indian/Alaskan Native □ Asian/Pacific Islander □ White/Caucasian □ Refused/undetermined □ Multiracial □ Black	ETHNICITY □ Hispanic or Latino □ Not Hispanic or Latino □ Refused/undetermined	PREFERRED CONTACT METHOD (Check all that apply) □ Home Address (letters) □ Home Phone □ Cell Phone	
REASON FOR VISIT	**PREFERRED PHARMACY**		
REFERRING DOCTOR	**PRIMARY CARE PHYSICIAN**		

RESPONSIBLE PARTY

NAME- Last First Middle		DATE OF BIRTH	SEX □ Male □ Female
ADDRESS		TELEPHONE - HOME	TELEPHONE - WORK
RELATIONSHIP TO PATIENT □ Parent □ Guardian □ Other	SOCIAL SECURITY NUMBER	EMPLOYER	

PRIMARY INSURANCE CARRIER			**SECONDARY INSURANCE CARRIER**		
INSURANCE CARRIER NAME			INSURANCE CARRIER NAME		
INS ID #	GROUP #	COPAYMENT	INS ID #	GROUP #	COPAYMENT
SUBSCRIBER (POLICY HOLDER) NAME: _____ ADDRESS:_____ PHONE#: SS#: BIRTHDATE:			SUBSCRIBER (POLICY HOLDER) NAME: _____ ADDRESS:_____ PHONE#: SS#: BIRTHDATE:		
PATIENT-SUBSCRIBER RELATIONSHIP □ Self □ Spouse □ Dependent □ Other			PATIENT-SUBSCRIBER RELATIONSHIP □ Self □ Spouse □ Dependent □ Other		

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME	DAYTIME TELEPHONE	EVENING TELEPHONE
STREET ADDRESS CITY STATE ZIP CODE		

ALL PAYMENTS ARE DUE AT TIME OF SERVICE

Assignment of Benefits/Financial Agreement. I certify that the registration information I provided is true and accurate. I authorize payment of health insurance benefits directly to Urology Surgical Consulting, PC (USC). I understand the following: I am responsible for all fees deemed my responsibility. It is my responsibility to provide a referral if required by my insurance. If I do not have a referral, my appointment may be rescheduled or I may be responsible for all charges. I will pay my co-pay at time of service if one is due. I am responsible for all fees deemed my responsibility according to USC and my health plan. If I do not provide a VALID insurance card before services are provided, I will be held responsible for ALL charges. I agree to pay any outstanding amounts, including interest and any associated fees if my account is referred to a collection agency. It is my responsibility to determine which outside facilities participate with my insurance plan, which services require authorization, and that errors may result in my responsibility of fees. It is USC's policy that prescription refill requests are processed only with proper follow-up visits and during normal business hours**. I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM THE PATIENT OR PERSON AUTHORIZED TO ACT ON BEHALF OF THE PATIENT AND AGREE TO TERMS HEREIN. I understand that I may be contacted by USC on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages and/or an automated dialing device (auto dialer), by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services.**

Patient's Signature: _____ Date: _____
Or
Signature of Patient's Representative: _____ Relationship to Patient: _____