

**THE CENTER FOR MEN'S AND WOMEN'S UROLOGY, LLC**  
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**PATIENT REGISTRATION**

**PATIENT INFO**

**Primary Care Physician?** \_\_\_\_\_ **Who referred you to our office?** \_\_\_\_\_

Patient Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Is it OK to leave test results and messages on answering machine? \_\_\_ Yes \_\_\_ No

Work Phone: (\_\_\_\_) \_\_\_\_\_ May we contact you at this number? \_\_\_ Yes \_\_\_ No

Cell Phone: (\_\_\_\_) \_\_\_\_\_ May we leave test results and messages on your voice mail? \_\_\_ Yes \_\_\_ No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Email address \_\_\_\_\_

Employer Address \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Spouse/Parent \_\_\_\_\_ Social Security # \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Spouse DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT: (not living with you)**

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship to Patient? \_\_\_\_\_

**INSURANCE INFO:**

**PRIMARY INSURANCE:** \_\_\_\_\_ Subscriber/Insured DOB \_\_\_\_\_

Policy or I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber/Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Subscriber/Insured DOB: \_\_\_\_\_

Policy or I.D.#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber/Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

**PREFERRED PHARMACY:** \_\_\_\_\_ Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**Please sign and return to the receptionist.**

*I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.*

Are you currently on a pain contract with another physician? Yes \_\_\_\_\_ NO \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_