



Patient Registration Form

PATIENT INFORMATION (please print clearly)

Last Name: _____ First: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home # _____ Work # _____ Cell # _____

May we leave a personal message on your answering machine regarding any or all ongoing medical conditions? Y___ N___

Do we have permission to talk to another person (spouse, family member) about your medical condition or finances? Y___ N___

IF YES, name of person: _____ Relationship to you: _____

May we call you at work? Y___ N___ May we call your cell phone? Y___ N___ May we contact you by Email? Y___ N___

IF YES – email address: _____ SOCIAL SECURITY #: _____

DOB: _____ AGE: _____ SEX: M___ F___ Spouse/partner name: _____

Married:___ Single:___ Partnered:___ Widowed:___ Separated:___ Divorced:___

Employer: _____ Occupation: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Relationship of Emergency Contact: _____

INSURANCE-PRIMARY: _____

Primary Subscriber Name: _____ DOB: _____ Employer: _____

ID # _____ Group # _____

INSURANCE-SECONDARY: _____

Subscriber Name: _____ DOB: _____ Employer: _____

ID # _____ Group # _____

I hereby authorize CLEVELAND UROLOGIC SURGERY, PA to furnish information to insurance carriers concerning my illness and treatment needed to determine benefits payable. I understand that sensitive material from my medical history could be included. I hereby assign to CLEVELAND UROLOGIC SURGERY, PA all payments for medical services rendered to myself or my dependents. This assignment will remain in effect until revoked by me in writing. I understand I have financial responsibility for all charges whether or not paid by my insurance.

Signed: _____ Date: _____

Internal Use Only

Review date/by: 2010 _____ 2011 _____ 2012 _____ 2013 _____ 2014 _____ 2015 _____ 2016 _____