Urology Associates Medical Group, P.C.

Patient Registration

Patient Information

Last Name_____ Middle Initial_____ First Name _____

Mailing Address_____City_____State_____Zip_____

Primary Telephone_____ Other Telephone_____

Date of Birth ____/____/_____ Social Security_____ Marital Status_____

Sex: Male Female Employment Status: Retired Employed Unemployed

Occupation_____ Employer_____Email_____

Emergency Contact:_____ Relationship_____ Telephone_____

Responsible Party (if different from patient)

First Name_____ Middle Initial_____ Last Name _____

Adress_____City_____State_____Zip_____

Primary Telephone_____ Other Telephone_____

Date of Birth ____/____/_____ Social Security_____ Marital Status_____

Sex: Male Female Employment Status: Retired Employed Unemployed

Occupation_____ Employer_____Email_____

Medical Information

Referring Physician_____ Address_____

Primary Care Physician_____Address_____

Preferred Pharmacy_____

Workman's Compensation: Yes No Claim #_____

Reason for being seen today:_____

Insurance Information

Primary Insurance Company_____ Policyholder Name_____

Relationship to Policyholder: Self Spouse Child Other Policyholder DOB: ____/____/_____

Policy ID# _____

Secondary Insurance Company_____ Policyholder Name_____

Relationship to Policyholder: Self Spouse Child Other Policyholder DOB: ____/____/_____

Policy ID# _____

Insurance Information Provided: I hereby authorize Urology Associates of Jackson, WY to release necessary medical information to my insurance company (ies). I further authorize direct payment to the above entities from the above listed companies. I understand that I am responsible for obtaining referrals, if necessary, and pay any co-payments, coinsurance or deductibles required by my Plan. I also understand that I may be responsible for the full amount in the event of non-coverage determined by my Plan. If my account is not paid when due, I further agree to pay collection expenses of 25% of the balance plus interest accrued after 90 days at 1.5% monthly.

No Insurance Information Provided: I agree to pay in full by cash, check, credit card or money order at or before the date of service, unless I qualify for financial assistance. If my account is not paid when due, I further agree to pay collection expenses and or attorney fees in the amount of 25% of the balance due, plus interest of 1.5% per month on any balance outstanding for 90 days or more.

Service will be provided only if financial arrangements are made at or before the time of service.

Patient/Guardian Signature_____ Date_____