REGISTRATION

PATIENT INFORMATION

Last Name	First	MI	☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss

Date of Birth	Age	Race	Sex ☐ M ☐ F	Social Security Number	Marital Status ☐ S ☐ M ☐ D ☐ W ☐ Sep

Street Address	City	State	Zip Code	Home Phone ( )

Email Address	Cell Phone ( )

Patient's Occupation	Employer	Employer Phone ( )

Spouse's Last Name	First	MI	☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss

Spouse's Occupation	Employer	Employer Phone ( )

Chose Urology Associates of NE Florida Because (Please check one box) ☐ Insurance Plan ☐ Family ☐ Friend ☐ Internet ☐ Yellow Pages ☐ Other	Ethnicity	Preferred Language

Other Family Members Seen at Urology Associates of NE Florida

INSURANCE INFORMATION (Please give your insurance card(s) to the receptionist)

Primary Insurance	Policy #	Group #

Subscriber's Name	Social Security #	Date of Birth	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance	Policy #	Group #

Subscriber's Name	Social Security #	Date of Birth	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY CARE PHYSICIAN

Last Name	First	MI	Specialty

Street Address	City	State	Zip Code	Office Phone ( )

REFERRING PHYSICIAN (IF DIFFERENT THAN PRIMARY CARE PHYSICIAN)

Last Name	First	MI	Specialty

Street Address	City	State	Zip Code	Office Phone ( )

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone ( )	Work Phone ( )

PHARMACY

Pharmacy Name (first choice)	Location	Phone Number ( )
Pharmacy Name (second choice)	Location	Phone Number ( )

CERTIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Urology Associates of NE Florida or insurance company to release any information required to process my claims.

X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature
	Patient/Legal Guardian/Authorized Person (Printed Name)	Relationship If Other Than Patient