

# Associated Urologists of North Carolina, P A

[www.AssociatedurologistsofNC.com](http://www.AssociatedurologistsofNC.com)

## Patient Registration Form

DATE: \_\_\_\_\_ REFERRED BY \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_ SEX: M F

SPOUSE NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_ SEX: M F

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ MARITAL STATUS: MARRIED SEPARATED SINGLE DIVORCED WIDOWED

IF PATIENT IS A CHILD:

PARENT/GUARDIAN NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### ADDITIONAL INFORMATION

FAMILY MD \_\_\_\_\_ PHONE \_\_\_\_\_ PHARMACY: \_\_\_\_\_ PHONE \_\_\_\_\_

PATIENT/PARENT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

NEXT OF KIN: NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

(SOMEONE WHO DOES NOT LIVE WITH YOU, IN CASE OF EMERGENCIES) **INSURANCE INFORMATION**

#### PRIMARY INSURANCE

#### SECONDARY INSURANCE

NAME OF INS. CO. \_\_\_\_\_ NAME OF INS. CO. \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_

RELATIONSHIP TO POLICY HOLDER: RELATIONSHIP TO POLICY HOLDER:

\_\_\_ SELF \_\_\_ SPOUSE  
\_\_\_ CHILD \_\_\_ OTHER

\_\_\_ SELF \_\_\_ SPOUSE  
\_\_\_ CHILD \_\_\_ OTHER

MEMBER ID # \_\_\_\_\_ MEMBER ID # \_\_\_\_\_

GROUP # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_ GROUP # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

PHONE # TO VERIFY BENEFITS \_\_\_\_\_ PHONE # TO VERIFY BENEFITS \_\_\_\_\_

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THIS OFFICE OF PRE-ADMISSION CERTIFICATION AND /OR SECOND OPINION REQUIREMENTS OF THEIR INSURANCE COMPANY AT THE TIME OF SCHEDULING HOSPITAL ADMISSIONS OR SURGERY. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION PERTINENT TO MY CARE TO MY REFERRING PHYSICIAN/FAMILY PHYSICIAN AND INSURANCE COMPANIES AND ACCEPT RESPONSIBILITY FOR PAYMENT OF ALL MEDICAL/SURGICAL FEES. I ALSO AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO ASSOCIATED UROLOGISTS OF NORTH CAROLINA, EXCEPT WHEN THE AMOUNT HAS BEEN PAID IN FULL BY ME.

SIGNED: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICARE PATIENTS:** I REQUEST THAT PAYMENT UNDER THE MEDICARE INSURANCE PROGRAM BE MADE DIRECTLY TO ASSOCIATED UROLOGISTS OF NORTH CAROLINA, P.A ON ANY BILLS FOR SERVICE FURNISHED BY THEIR PHYSICIANS DURING MY LIFETIME. I UNDERSTAND THAT I MAY BE HELD RESPONSIBLE FOR A PORTION OF THESE BILLS AFTER MEDICARE HAS PAID THE PROVIDER, OR FOR CHARGES MEDICARE DOES NOT COVER.

SIGNED: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_