PATIENT REGISTRATION FORM

CURRENT PATIENT INFORMATION – PLEASE PRINT

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____

Sex: (*please circle*): Male or Female

Date of Birth: _____

Social Security No: _____

Patient Email: _____

Patient Referred By: _____

Primary Care Provider: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Patient: _____

Phone: ( ) _____ - _____

EMPLOYMENT INFORMATION

Employment (*please circle*) FT / Not Employed / Retired

Employer: _____

Address: _____

Phone: ( ) _____ - _____

REQUIRED BY GOVERMENT MANDATE (*YOU MAY REFUSE*)

Language (*please circle*): English / Spanish / Other: _____

Race *(please circle)*: White / Asian / Native American / African American Native Hawaiian or Other Pacific Islander / Declined

Ethnicity (*please circle):* Hispanic or Latino / Non Hispanic or Latino / Declined

Marital Status (*please circle*): Married / Single / Divorced

PHARMACY INFORMATION

Name: _____

Crossroads: _____

Phone ( ) _____ - _____

MAIL ORDER PHARMACY/PRESCRIPTION CARD

Name: _____

Address: _____

Phone: ( ) _____ - _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____

ID Number: _____

Group Number: _____

Policy Holder Name: _____

Date of Birth: _____ Sex *(please circle)*: M or F

Patient's relationship to policy holder: _____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____

ID Number: _____

Group Number: _____

Policy Holder Name: _____

Date of Birth: _____ Sex *(please circle)*: M or F

Patient's relationship to policy holder: _____

RELEASE OF INFORMATION

I, _____hereby authorize Southwest Urologic Specialists to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship: _____ Phone ( ) _____ - _____

Name: _____ Relationship: _____ Phone ( ) _____ - _____

Name: _____ Relationship: _____ Phone ( ) _____ - _____

*** PLEASE SIGN AND DATE EACH ITEM BELOW ***

ACKNOWLEDGEMENT AND AUTHORIZATIONS:

- **I have read and understand the HIPAA/Privacy Policy for Southwest Urologic Specialists.**

Signed: _____ **Date:** _____

- **I have read and understand the Financial Policy for Southwest Urologic Specialists.**

Signed: _____ **Date:** _____

- **AUTHORIZATION TO BILL PAY:** I hereby authorize Southwest Urologic Specialists, to release any information required in the course of my examination or treatment to my Insurance(s). I also herby authorize payment directly to Southwest Urologic Specialists, for the surgical and /or medical benefits, if any otherwise payable to me for services rendered. I understand that I am Financially responsible for all charges not covered by my Insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) for today's visit, and all future visits with Southwest Urologic Specialists, and will pay all fees involved should my account(s) be placed with a collection service. Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.

Signed: _____ **Date:** _____