

THE UROLOGY CLINIC
GEORGIA LITHOTRIPSY & LASER CENTER®

PATIENT REGISTRATION FORM

NAME (FIRST) _____ (MI) _____ (LAST) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # (_____) _____ CELL # _____ WORK # _____

EMPLOYER _____ ADDRESS _____

SOCIAL SECURITY # _____ REFERRED BY _____

SEX (Circle) M F MARITAL STATUS _____ DATE OF BIRTH ____/____/____

HOW DID YOU HEAR ABOUT US? (i.e., radio ad/friend/Dr. referral, etc.) _____

SPOUSE OR PARENT NAME _____ DOB: _____ ADDRESS _____

SPOUSE OR PARENT EMPLOYER _____ PHONE # (_____) _____

EMPLOYER ADDRESS _____

REASON FOR VISIT _____

PREFERRED PHARMACY _____ PHONE # _____

EMERGENCY CONTACT NAME _____ PHONE # _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIED BY PATIENT

SECONDARY INSURANCE

Insurance Co. Name: _____

Insurance Co. Name: _____

Phone #: _____

Phone #: _____

Policy #: _____

Policy #: _____

Group or Member #: _____

Group or Member #: _____

Insured DOB: _____

Insured DOB: _____

Name of Insured: _____

Name of Insured _____

Patient Relationship to Policy Holder: _____

Patient Relationship to Policy Holder: _____

I authorize The Urology Clinic, P.C. to release to my insurance company any information required in the course of my examination or treatment. I also authorize any physician, hospital, or clinic to provide details of my history to The Urology Clinic, P.C.

PATIENT SIGNATURE _____ **DATE** _____

I hereby assign payment directly to The Urology Clinic, P.C. for medical benefits payable for these services. I understand I am responsible for payment of all services rendered regardless of insurance coverage.

PREFERRED METHOD OF PAYMENT: CHECK CASH VISA/MASTERCARD

PATIENT SIGNATURE: _____ **DATE** _____