PPART #:______________

PATIENT REGISTRATION FORM (Please print)

PATIENT NAME: (Last)______________________________**(First)**__________________ **(MI)**_______

Address____

City ________________________**State** _________ **Zip**____________**Email address**____________________

Home Phone (_______) _________ - ______________ **Work Phone** (___)________-_______ext_________

Social Security # _________-_________-________ **Birth Date** ____ /_____ /_____ **Sex:** Male ☐ Female ☐

Referred by: Doctor ☐ Other patient ☐ Friend ☐ Insurance Co. ☐

Referring Physician Name_______________________________________**Phone**______________________

PATIENT OR GUARDIAN INFORMATION:

Marital Status: Single__ Married__ Widowed__

Divorced___**DriversLicense#**___________________**State**____

Occupation______________________________**Employer**____

EmployerAddress____

Spouse's name ___________________________________ **Work phone** (_____) ______ _______ext______

Emergency contact ___________________________**Phone** (_____) _______-_________Pager_____________

If patient is a minor: Father's name ________________________________ **Phone**_____________________

Mother's name ________________________________**Phone** ____________________

INSURANCE INFORMATION: (Primary insured holder's information)

Name of Insured

____

PLAN

#1____

Group #__________________________________**Policy #**__________________________________

Address____

City________________________________**State**________ **Phone** (______) ______ - _______________

PLAN

#2____

Group #_________________________________**Policy #**__________________________________

Address____

City________________________________**State**________ **Phone** (______) ______ - _______________

PRIMARY INSURED'S INFORMATION (Skip this section if insured is the patient)

Name of insured (or person financially responsible if uninsured)___________________________________

Relationship to patient _____________________ **Address**____

City ____________________________________ **State** ________ **Zip** ________________________________

Social Security #________/ _______ /_______ **Drivers license** _________________**DOB**: _____/_____/____

Occupation: ___________________________________ **Employer:** ___________________________________

Home Phone (________) ________-_____________ **Work Phone** (_________)_______-_____________

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorize Urology Clinics of North Texas to release any information necessary to process a claim for insurance benefits. I hereby authorize payment directly to the physician if the claim is approved.

Signature____ Date ___________________________

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