

REGISTRATION

PATIENT INFORMATION										
Last Name			First				MI	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss		
Date of Birth	Age	Race	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep				
Street Address			City		State	Zip Code	Home Phone ()			
Email Address										
Patient's Occupation		Employer				Employer Phone ()				
Spouse's Last Name			First				MI	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss		
Spouse's Occupation		Employer				Employer Phone ()				
Chose Urology Center of Florida Because (Please check one box) <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other										
Other Family Members Seen at the Urology Center of 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance				Policy #			Group #			
Subscriber's Name		Social Security #		Date of Birth	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 the **Urology Center of 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