

CLINIC OF UROLOGY SC
REGISTRATION INFORMATION

DATE _____ HOME PHONE _____ CELL PHONE _____

PATIENT _____
(LAST NAME) (FIRST NAME) (M INITIAL)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

SEX M F AGE _____ BIRTHDATE _____ SINGLE MARRIED WIDOWED DIVORCED

EMPLOYED PATIENT EMPLOYED BY _____

BUSINESS ADDRESS _____
(CITY, STATE, ZIP)

OCCUPATION _____ BUSINESS PHONE _____

FULL TIME STUDENT PART TIME STUDENT

PATIENTS SCHOOL NAME _____

SPOUSE'S NAME _____ BIRTHDATE _____

OCCUPATION _____ BUSINESS PHONE _____

RESPONSIBLE PARTY (IF A MINOR) _____

RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

DO YOU HAVE MEDICAL INSURANCE? YES NO IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION

NAME OF PRIMARY INSURER _____ INSURED PARTY _____

GROUP # _____ SUBSCRIBER # _____

SECONDARY INSURER (IF ANY) _____ INSURED PARTY _____

GROUP # _____ SUBSCRIBER # _____

ARE YOU COVERED UNDER ANY OF THESE PROGRAMS? MEDICARE MEDICAID/T19 CHAMPUS/TRICARE
 CHAMPVA WORKMAN'S COMPENSATION FECA BLACK LUNG ID # FOR PROGRAM _____

IS CONDITION RELATED TO EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

IS CONDITION RELATED TO AN AUTO ACCIDENT? YES NO IF YES, IN WHAT STATE? _____

OTHER ACCIDENT? PLEASE EXPLAIN _____

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED? _____

PHONE _____ RELATIONSHIP TO PATIENT _____

PLEASE LIST ANY DOCTORS YOU HAVE SEEN IN THE PAST 5 YEARS:

(GENERAL PRACTITIONER, SPECIALIST OR OTHER) CITY, STATE _____

REASON FOR SEEING _____

(GENERAL PRACTITIONER, SPECIALIST OR OTHER) CITY, STATE _____

REASON FOR SEEING _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

REASON FOR YOUR VISIT _____

MEDICARE RELEASE (SIGN ONLY IF COVERED BY MEDICARE)

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE CLINIC OF UROLOGY SC FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. I AUTHORIZE ANY RELEASE OF PERTINENT MEDICAL INFORMATION REGARDING MY CARE TO ANY AUTHORIZED HEALTH CARE PROVIDER AND ITS AGENTS INCLUDING INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT MY SIGNATURE REQUESTS THE PAYMENT BE MADE AND AUTHORIZES THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE IS INDICATED IN ITEM 9 OF THE HCFA-1500 FORM, OR ELSEWHERE ON ANY OTHER APPROVED CLAIM FORM OR ELECTRONICALLY SUBMITTED CLAIM, MY SIGNATURE AUTHORIZES RELEASE TO THE INSURANCE OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES.

SIGNATURE

DATE

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO THE CLINIC OF UROLOGY SC ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HERBY AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE CLAIM FORMS, MANUAL OR ELECTRONIC. I ALSO RECOGNIZE THAT I AM FULLY RESPONSIBLE FOR ANY CHARGES INCURRED IF I DO NOT SUPPLY THE CLINIC WITH A PROPER REFERRAL FORM IF MY INSURANCE REQUIRES IT.

SIGNATURE

DATE