Northeast Georgia Urological Associates

# PATIENT REGISTRATION FORM

**PATIENT INFORMATION** **DATE:** _____

Name_____Nickname_____

Street Address_____City_____State_____Zip_____

Mailing Address_____City_____State_____Zip_____

Phone Numbers: Home (  )____-_____Work (  )____-_____Cell (  )____-_____Email Address_____

Referring Physician: _____Telephone (  )____-_____

Birthday ____/___/____ Age____Sex_____Ethnicity _____Social Security # _____ - ____ - _____ Marital Status ____

Patient's Employer_____ Occupation _____

Business Address_____City_____State_____Zip_____

Spouse's Name_____Birthday ____/___/____ Social Security # _____ - ____ - _____

Spouse's Employer_____ Occupation _____

**PATIENT INFORMATION (IF PATIENT IS UNDER 18-YEARS OLD)**

Father's Name_____Birthday ____/___/____ Social Security # _____ - ____ - _____

Street Address_____City_____State_____Zip_____

Father's Employer_____ Work (  )____-_____Cell (  )____-_____.

Business Address_____City_____State_____Zip_____

Mother's Name_____Birthday ____/___/____ Social Security # _____ - ____ - _____

Street Address_____City_____State_____Zip_____

Mother's Employer_____ Work (  )____-_____Cell (  )____-_____.

Business Address_____City_____State_____Zip_____

****** PLEASE INDICATE WHICH PARENT IS PRESENTING THE CHILD FOR TREATMENT BY CIRCLING PARENT'S NAME ******

**EMERGENCY CONTACT—PERSON NOT LIVING WITH PATIENT (A RELATIVE OR FRIEND)**

Name_____Contact: Home (  )____-_____Work (  )____-_____Cell (  )____-_____

Referring Physician _____ Family Physician_____

**WHAT TYPE OF INSURANCE PLAN (IF ANY) WILL YOU BE USING FOR YOUR CHARGES?**

☐ PPO ☐ HMO ☐ POS ☐ MEDICARE ☐ MEDICAID ☐ WORKER'S COMP ☐ SELF-PAY ☐ OTHER

Primary Policy Holder: Name _____DOB____/___/____ SS # _____ - ____ - _____ Sex___

Secondary Policy Holder: Name _____DOB____/___/____ SS # _____ - ____ - _____ Sex___

**WHAT METHOD OF PAYMENT DO YOU PLAN TO USE FOR YOUR CO-PAYMENT AND/OR CO-INSURANCE?**

☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ CARE CREDIT

**PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE & IDENTIFICATION CARDS. THANK YOU.**

_____ _____ _____

DATE PATIENT OR GUARANTOR WITNESS