ADULT AND PEDIATRIC UROLOGY GROUP: ADULT REGISTRATION FORM

Please complete the entire registration form. Thank you for your time and patience.

Patient's Name: _____ Home Phone#:
Last First Middle _____

Street Address: _____ Cell #: _____

City: _____ State: _____ Zip Code: _____

Employer Name: _____ Occupation: _____ Work Phone#:

Street Address: _____ _____

City: _____ State: _____ Zip Code: _____

Patient's Sex: Male Female Patient Social Security#: _____

Patient Date of Birth: _____ Patient Marital Status: M S D W

Spouse's Full Name: _____
Last First Middle

Patient's Primary Care Doctor: _____ Doctor who Referred(if different from primary): _____
Phone: _____Address: _____ Phone: _____ Address: _____

Emergency Contact: _____ Phone#:_____ Relationship:_____

Pharmacy Name: _____ Town:_____ Phone#:_____

INSURANCE INFORMATION **(Must be completed in full so that we may submit to your insurance for reimbursement.)**

Primary Insurance: _____

Policyholder's Information:

Name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #:_____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

Secondary Insurance: _____

Policyholder's Information:

Name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #:_____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Adult and Pediatric Urology Group, for any service furnished to me by APU's physicians. I authorize Adult and Pediatric Urology Group to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary.

Signature:_____ **Date:** _____