Texas Center for Urology

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PATIENT REGISTRATION FORM

Today's Date: ________________________________ *Clinic Name:* ___________________________

PATIENT INFORMATION: (Please use legal name, no nicknames)

*Last name: _____________________________ *First Name: _______________________*Middle Initial: _______

*Address: ____ *Zip Code: ___________

*City: _________________________________ *State: ___________________________ *County: ___________________

*Home Phone #: _____________________ *Social Security#: _________________________ *DL#: ___________________

*Date of Birth: _______________________ *Age: ______ *Sex :______ *Marital Status: __________________

*Employer Name and Address: ____ *Work#: ___________________

*Email Address: ____ *Cell Phone#: ___________________________

*Emergency Contact Name: ________________________________ * Emergency Phone #: ______________________

Please tell us how you heard about us: ____________________ Referred by: ______________________________

GUARANTOR INFORMATION: (list person or insured name responsible for the bill, use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self ______ Spouse ______ Parent _______ Other _______

*Last name: _____________________________ *First Name: _______________________*Middle Initial: _______

*Address: ____ *Zip Code: _________________

*City: _________________________________ *State: ___________________________ *County: ___________________

*Home Phone #: _____________________ *Social Security#: _________________________ *DL#: ___________________

*Date of Birth: _______________________ *Age: ______ *Sex: _____ *Marital Status: ______________________

*Employer Name and Address: ____ *Work Phone #: __________________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

*Plan Name: _____________________________________ *Insured's Name: ___________________________________

*Insured's Social Security#: __________________________ *Insured's Date of Birth: ______________________________

*Policy/ID#: ______________________ *Group#: __________________________ Effective Date: _________________

*Claims Address & Phone#: ____

SECONDARY INSURANCE:

*Plan Name: _____________________________________ *Insured's Name: _________________________________

*Insured's Social Security #: __________________________ *Insured's Date of Birth: _____________________________

*Policy/ID #: ______________________ *Group#: _________________________ Effective Date: __________________

*Claims Address & Phone #: ____