UROLOGY ASSOCIATES OF SAN LUIS OBISPO

A Medical Group, Inc.

PATIENT REGISTRATION INFORMATION

PLEASE PRINT

PATIENT NAME: _____
LAST FIRST M.I.

ADDRESS: _____ **SEX : F / M**
STREET CITY STATE ZIP

HOME PHONE: _____ **CELL PHONE:** _____ **MARITAL STATUS: S / M / O / D**

BIRTH DATE: _____ **AGE:** _____ **SOCIAL SECURITY #:** _____ - _____ - _____

PREFERRED LANG. : _____ **RACE :** _____ **ETHNICITY :** _____

OCCUPATION: _____ **EMPLOYER:** _____ **ADDRESS:** _____

BUSINESS PHONE: _____ **SPOUSE'S NAME:** _____

SPOUSE'S OCCUPATION: _____ **SPOUSE'S EMPLOYER:** _____

CHILDREN'S NAMES: _____

WHO MAY WE RELEASE MEDICAL INFORMATION TO: _____

E-MAIL ADDRESS: _____

RESPONSIBLE PARTY INFORMATION (ONLY IF OTHER THAN PATIENT)

NAME (LAST, FIRST, MI): _____ **PHONE :** _____

ADDRESS: _____
STREET CITY STATE ZIP

REFERRED BY: _____ **PRIMARY CARE PHYSICIAN:** _____

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU | **RELATIONSHIP** | **PHONE NUMBER**

******INSURANCE INFORMATION******

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE:** _____
SUBSCRIBER: _____ **SUBSCRIBER:** _____
RELATIONSHIP TO PATIENT: _____ **RELATIONSHIP TO PATIENT:** _____
SUBSCRIBER'S BIRTH DATE: _____ **SUBSCRIBER'S BIRTH DATE:** _____

EMPLOYER'S INSURANCE PLAN: YES NO EMPLOYER'S INSURANCE PLAN: YES NO

******I ACKNOWLEDGE THAT PAYMENT IS DUE ON THE DATE OF SERVICE FOR SERVICES RENDERED INCLUDING BUT NOT LIMITED TO : COPAY, DEDUCTIBLE, SUPPLIES, OR IF I DO NOT HAVE INSURANCE, PAYMENT IN FULL WILL BE COLLECTED AT TIME OF SERVICE. THEREFORE, I ALSO UNDERSTAND THAT THERE IS REQUIRED INFORMATION THAT WILL BE SENT TO MY INSURANCE COMPANY IN ORDER FOR THE DOCTOR TO RECEIVE PAYMENT FOR SERVICE PERFORMED******

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE