UROLOGY ASSOCIATES OF SAN LUIS OBISPO

A Medical Group, Inc.

Patient Registration for Minors

Please print

Patient's name: _____
Last First M.I.

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Social Security: _____

Sex: M/F _____ Age: _____ Birth date: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Parent/Guardian/Guarantor Relationship to Patient _____

Name (Last, First, MI): _____ Phone: _____

Address: _____
Street City State Zip

Who has legal custody? _____

Is custody shared? ☐ Yes ☐ No If yes, by who _____

Employed by: _____ Address: _____

Occupation: _____ Bus. Phone: _____ Cell phone: _____

Second Parent/Guardian Relationship to Patient _____

Name (Last, First, MI): _____ Phone: _____

Address: _____
Street City State Zip

Employed by: _____ Address: _____

Occupation: _____ Bus. Phone: _____ Cell phone: _____

Referred by: _____

Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of Carrier: _____

Street Address: _____

City, State, Zip: _____

Insurance ID No.: _____

Group #: _____

Subscriber: _____

Relationship to patient: _____

Subscriber Birth date: _____

Employers Insurance Plan: ☐ Yes ☐ No

Secondary Insurance: _____

Name of Carrier: _____

Street Address: _____

City, State, Zip: _____

Insurance ID No.: _____

Group #: _____

Subscriber: _____

Relationship to patient: _____

Subscriber Birth date: _____

Employers Insurance Plan: ☐ Yes ☐ No

I ACKNOWLEDGE THAT PAYMENT IS DUE ON RECEIPT OF A STATEMENT FOR SERVICES RENDERED. I AGREE TO PAY A LATE PAYMENT CHARGE OF 1% PER MONTH ON THE UNPAID BALANCE OF MY ACCOUNT THAT IS DELINQUENT 60 DAYS OR MORE. IF MY ACCOUNT IS REFERRED TO COLLECTION, I ALSO AGREE TO PAY REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSES.

_____ _____

PARENT/GUARDIAN/GUARANTOR SIGNATURE Date