Patient Registration Form

Patient's Legal Name: Last ______ First ______ Middle ______

S.S.# ______ ❑ Female ❑ Male D.O.B. ______ Age ______

Marital Status ❑ M ❑ S ❑ D ❑ W Personal E-mail ______ Work E-mail ______

Home Address ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Occupation (or none, student, homemaker, retired) ______ Employer ______

We are required to ask the following questions due to the American Recovery and Reinvestment Act of 2009 (ARRA)

Race: ❑ Black or African American ❑ American Indian or Alaska Native ❑ Asian ❑ Hawaiian or Other Pacific Islander ❑ Other ❑ White

Preferred Language: ❑ English ❑ Other ______

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Spouse's Name ______ D.O.B. ______ S.S.# ______

Employer ______ Occupation ______ Phone ______

Whom May We Contact in Case of Emergency? ______

Relationship ______ Phone 1 ______ Phone 2 ______

Guarantor ______ Patient's Legal Guardian ______

Father's Name ______ D.O.B. ______ S.S.# ______

Father's Home Address ______ City/State/Zip ______ Phone ______

Father's Employer ______ Occupation ______ Work Phone ______

Mother's Name ______ D.O.B. ______ S.S.# ______

Mother's Home Address ______ City/State/Zip ______ Phone ______

Mother's Employer ______ Occupation ______ Work Phone ______

Primary Insurance Company Name ______

Subscriber Name ______ ❑ Self ❑ Spouse ❑ Parent ❑ Child ❑ Step Parent ❑ Other

Secondary Insurance Company Name ______

Subscriber Name ______ ❑ Self ❑ Spouse ❑ Parent ❑ Child ❑ Step Parent ❑ Other

Please bring your insurance card and a photo I.D. with you to your appointment. These will be used to verify your information and to help protect your identity.

Primary Care Physician ______ Date Last Seen ______ Referring Physician ______ Date Last Seen ______

Date of Last Lab Work ______ X-Ray ______ CT Scan ______ MRI ______

Location ______ Preferred Pharmacy ______

Who referred you to our practice?

❑ Physician ❑ E/R ❑ Internet ❑ Yellow pages ❑ Newspaper ❑ T.V. ❑ Radio ❑ Ad in Magazine ❑ Community Event ❑ Other ______

❑ Family/Friend ______ May we use your name in thanking this person? ❑ Yes ❑ No Signature ______

Family/Friend ______
Address City Zip

Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to Idaho Urologic Institute, P.A. and/or Surgery Center of Idaho, LLC and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Idaho Urologic Institute, P.A. and/or Surgery Center of Idaho, LLC to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign here: ______ Date: ______

I acknowledge receipt of a copy of Idaho Urologic Institute, P.A. and/or Surgery Center of Idaho, LLC's Notice of Privacy Practice. A copy will be available at our office.

Sign here: ______ Date: ______