Urological Associates of Southern Arizona, P.C Patient Registration Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name_____ Responsible Party: _____

Address _____ City, State _____ Zip Code _____

Home Phone _____ Business Phone _____ Cell Phone _____

Contact Preference: Home _____ Day _____ Cell _____ Patient Portal _____

Relationship to Patient: Self ____ Spouse ____ Child ____ Other ____ Patient Email _____

Patient Date of Birth _____ Sex: Male _____ Female _____ Responsible Party Date of Birth _____

Referring Primary Care Physician _____ Is patient: Single ____ Married ____ Other ____

If injury is related to an accident, was it: Auto Accident ____ Job Related Injury ____ Date of Injury _____

Emergency Contact Name/Address/Phone _____

I give consent for my medical information to be shared with _____Relationship to Patient_____

Advance Health Care Directives? Yes _____ No _____ Copy Filed With (name) _____ Phone _____

Are you living in a long term care facility/nursing home/skilled nursing facility? If yes, Address/Phone: _____

I give consent for my labs/test results to be left on my voicemail/answering machine at _____

Pharmacy Preference _____ Address/Phone _____

Contact Preference: None ___, Patient Portal ___, Home Phone ___, Alt Phone ___, Cell Phone ___, Day Phone ___, Mail _____

INSURANCE INFORMATION

Primary Insurance Company Name/Address _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Sex: Male _____ Female _____ Date of Birth _____

Employer _____ Policy Number _____ Group/Claim Number _____

Secondary Insurance Company Name/Address _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Sex: Male _____ Female _____ Date of Birth _____

Employer _____ Policy Number _____ Group/Claim Number _____

Assignment of Benefits: I request that payment of authorized benefits be made on my behalf. I assign the payment of those benefits to which I am entitled, including private insurance and other health plans to Urological Associates of Southern Arizona, PC

Consent to Treat: I give my consent for the licensed health care professionals of Urological Associates of Southern Arizona to examine my person, perform medical diagnostic studies and give medical treatment which is consistent with the standards of medical care.

My signature below affirms my patient registration information and acceptance of the financial terms, responsibilities and consents as stated herein.

Signed: _____ Relationship: _____ Date: _____

(Patient or parent if under 18yrs old)