

Advanced Urology Associates, L.L.C.

PATIENT REGISTRATION

Please Print

Patient Name: First: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Marital Status: (Circle One) **S M D W Separated**

Home Address: _____ Apt. No. _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Social Security #: _____

Spouse's Name: (If Applicable) _____ Patient Sex: **Male Female**

If patient is a minor:

Legal Guardian: _____ Relationship to Patient: _____

Address: (If Different From Above) _____

Phone: (If Different From Above) _____

Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Work Phone: _____ Extension: _____

Name of Policy Holder: (If Different Than Patient) _____

Address of Policy Holder: (If Different Than Patient) _____

Relationship of Patient to Policy Holder: **Self Spouse Child Other** (Please Specify) _____

Phone Number of Policy Holder: (If Different Than Patient) _____

Policy Holder's Social Security Number: _____ Date of Birth: _____

Policy Holder's Employer: _____

Person To Notify In Case of Emergency: _____

Phone Number: _____ Relationship: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____

I authorize Advanced Urology Associates, L.L.C. and/or Reisterstown Ambulatory Surgical Center, to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to Advanced Urology Associates, L.L.C. and/or Reisterstown Ambulatory Surgical Center. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Signature of Subscriber or Beneficiary

Date