

REGISTRATION

PATIENT INFORMATION									
Last Name:			First			MI		<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	
Date of Birth	Age	Race	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security Number		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep		
Street Address			City		State	Zip Code	Home Phone ()		
Email Address									
Patient's Occupation			Employer			Employer Phone ()			
Spouse's Last Name:			First			MI		<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	
Spouse's Occupation			Employer			Employer Phone ()			
Chose Johnson City Urological Clinic Because (Please check one box) <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other									
Other Family Members Seen at the Johnson City Urological Clinic									
INSURANCE INFORMATION (Please give your insurance card(s) to the receptionist)									
Primary Insurance				Policy#			Group#		
Subscriber's Name		Social Security #		Date of Birth		Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Secondary Insurance				Policy#			Group#		
Subscriber's Name		Social Security #		Date of Birth		Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
PRIMARY CARE PHYSICIAN									
Last Name:			First			MI		Specialty	
Street Address			City		Zip Code	Office Phone ()			
REFERRING PHYSICIAN (If Different Than Primary Care Physician)									
Last Name:			First			MI		Specialty	
Street Address			City		Zip Code	Office Phone ()			
IN CASE OF EMERGENCY									
Name of Local Friend or Relative			Relationship to Patient			Home Phone ()		Work Phone ()	
PHARMACY									
Pharmacy Name (first choice)			Location				Phone Number ()		
Pharmacy Name (second choice)			Location				Phone Number ()		

CERTIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the **Johnson City Urologic Clinic** or insurance company to release any information required to process my claims.

X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature
X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature