Atlanta Urological Group, P.C.

Patient Registration Form

Date: _____ **Phone#**_____

Patient's Full Name: _____
Last **First** **Mid**

Patient Address: _____
Street **Apt#**

City:_____**State**:_____**ZIP**:_____

Age: ____**Birthdate**:____/____/____ **SS#** _____/____/_____(**Sex**: M / F **Marital Status:** S M W O (circle one)

Is the patient a student: YES NO Patient's Occupation:_____

Person Responsible for Bill: _____Relationship: _____

Address (if different from above): _____
Street City/State Zip

In Case of emergency, and we need to contact: Name: _____

Relationship to Patient: _____ Phone#: _____

Address: _____City/State_____ZIP: _____

PRIMARY MEDICAL INSURANCE: _____

Is this group insurance? Yes No Name of Company: _____

Name of subscriber: _____ID#: _____ Group#: _____

Subscriber Birthdate: ____/____/____ Relationship to Patient: _____ SS#: _____/_____/_____

Subscriber's Employer: _____

Employer's Address:_____

SECONDARY MEDICAL INSURANCE: _____

Is this group insurance? Yes No Name of Company: _____

Name of Subscriber: _____ID# _____ Group# _____

Subscriber Birthdate: ____/____/____ Relationship to Patient: _____ SS#: _____/_____/_____

Subscriber's Employer: _____

Employer's Address: _____

REFERRING PHYSICIAN: _____ **PHONE#:** _____
FAMILY PHYSICIAN: _____ **PHONE#:** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE ATLANTA UROLOGICAL GROUP, P.C. TO FURNISH INFORMATION TO ANY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT(S) HERE, AND I HEREBY AUTHORIZE ASSIGNMENT OF BENEFITS FOR MEDICAL/SURGICAL SERVICES RENDERED BY ATLANTA UROLOGICAL GROUP TO BE PAID DIRECTLY TO THE DOCTOR ON SERVICES RENDERED EITHER TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE.

Date: _____ Signature: _____