

Urology for Children, LLC - Patient Registration

Patient Information

Name: _____ Nickname: _____ D.O.B.: _____
SSN: _____ Phone #: _____
Home Address: _____

Guarantor Information (Responsible party other than patient)

Name: _____ Phone # (if different from patient): _____
Home Address (if different from patient): _____

Relationship to Patient: _____
Employer Name & Address: _____
Employer Phone #: _____

Insurance Information

Primary Insurance - Company Name: _____
Subscriber Name: _____ SS#: _____
Relationship to Patient: _____ D.O.B.: _____
Employer Name, Address & Phone #: _____
Member ID #: _____ Group #: _____

Secondary Insurance - Company Name: _____
Subscriber Name: _____ SS#: _____
Relationship to Patient: _____ D.O.B.: _____
Employer Name, Address & Phone #: _____
Member ID#: _____ Group #: _____

Emergency Contact (preferably someone at an alternate number than home phone)

Name: _____ Relationship to patient: _____
Phone #: _____

Referring Physician and/or Pediatrician

Name of physician and/or practice: _____ Phone #: _____
Address: _____

Assignment of Benefits

All charges are payable at the time of service unless we are participating providers with your insurance carrier. As participating providers, you are responsible at the time of service for any co-payment designated by your insurance carrier (if applicable). Upon payment, a receipt that is accepted by insurance carriers will be issued to you.

I hereby assign all medical benefits to Urology for Children, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize Urology for Children, LLC to release all information necessary to ensure payment.

I understand that I and/or my insurance carrier are financially responsible for all charges.

Signed: _____ Date: _____