Urology for Children, LLC- Patient Registration

PLEASE PRINT CLEARLY TO ENSURE CORRECT SPELLING/PUNCUATION IN OUR SYSTEM

Patient Information

Name: ___________________________________ Nickname: __________ Date of Birth: ____/____/____

SSN: ______________________________ Phone: (____)___________Cell: (____)____________

Home Address: ____ Apt#: ____

City: _________________State: ________ Zip Code: ________

Guarantor/Parent/Caretaker Information (Responsible party other than patient)

Name: ____ Date of Birth: ____/____/_____

SSN: _______________________________ Phone: (____) ____________ Cell: (____) __________

Home Address: _______________________________________ Apt#: ____

City: ___________________________State: ________ Zip Code: ________

Relationship to patient: _____________________ Parents email: _________________________________

Employer Name: ________________ Address: _____________________ Phone: (____) __________

Insurance Information (Insurance Subscriber)

YES WE DO NEED THIS INFORMATION COMPLETED ALONG WITH A COPY OF THE INSURANCE CARD

PRIMARY INSURANCE

Name of Insurance: ____

Subscriber Name: ___________________________ SSN: ____________ Date of Birth: ___/____/___

Patient ID#: ____________________ Group #: _________ Relationship to patient: ______________

Employer Name: ____ Phone: _______________________

Employer Address: ____

SECONDARY INSURANCE (If applicable)

Name of Insurance: ____

Subscriber Name: ___________________________ SSN: ____________ Date of Birth: ___/____/___

Patient ID#: ____________________ Group #: _________ Relationship to patient: ______________

Employer Name: ____ Phone: _______________________

Employer Address: ____

Emergency Contact Information (Preferably someone with an alternate phone number other than home)

Name: ________________________ Relationship to patient: ______________ Phone: __________________

Pediatrician/Referring Physician or Practice

Physician/Practice Name: ____

Phone: (____) ____________ Address: ____

Pharmacy Name: _______________________ Phone#: _______________ Location: _______________________________

Assignment of Benefits

All charges are payable at the time of service unless we are participating providers with your insurance carrier. As participating members, you are responsible at the time 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 herby 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 herby 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: __________________

200 Bowman Dr • Suite E-360 • Voorhees, NJ 08043
NJ 856-751-7880 • PA 888-876-7880 • Fax 856-751-9133

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Michael G. Packer, M.D., F.A.C.S., F.A.A.P.
Jonathan A. Roth, M.D., F.A.A.P.
Mark R. Zaontz, M.D., F.A.C.S., F.A.A.P.
Michelle Sheel, MSN, CPNP

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ______________________________, have received a copy of Urology for Children's Privacy Practices.

Signature: ______________________________ Date: ____________________

Relationship to patient ____

Patient Name: __________________________ Patient Date of Birth: ________________

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Cultural Competency:

State of New Jersey mandates that every physician document and barrier to care including cultural and linguistic needs in the medical record. Factor affecting care are visual and auditory factors which may impeded the member's ability to comprehend medical discussion. Language, cultural and/or religious customs, which may impact the provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decreasing health care disparities. When documenting cultural competency in the member's medical record, it's imperative to document if no barrier exist.

Please answer the following questions:

Do you have any impairment? (i.e. Visual, hearing, speech, learning, physical and language/cultural barrier)

Yes ___________ No ___________

What languages do you speak, read, and write? ____

Do you have any religious or cultural customs that the doctor should know about? Yes ___________ No ___________

If yes, please describe:

____

____

Advanced Directives: Advance directives are federal and state mandated Self-Determination Act enacted in 1990. This allows the patient to provide specific instruction and direction regarding his/her own medical care wishes if they become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions with your patient. Physicians need to ask and document in the medical record for all patients who are 18 years of age and older.

Please answer the following questions:

Is the patient 18 years or older? Yes ___________ No ___________

If "yes", Do they have a "Living Will" or Advanced Directive? Yes ___________ No ___________

If the patient is over the age of 12, the following questions must be answered:

Does the patient smoke cigarettes? Yes ___________ No ___________ If "yes" how many packs per day ___________

Is there any alochol or substance abuse? Yes ___________ No ___________

Patients Name: ____ Date of Birth: ________________________________

Signature(Parent/Guardian IF patient is under 18 years old): ____

Relationship to patient: ____ Date: ________________________________