Atlantic Urology medical group

PATIENT REGISTRATION

(Please Print & Complete in Full)

PATIENT INFORMATION			MEDICAL RECORD #	
First Name	Middle Initial	Last Name		
Address		City	State	Zip
Social Security #	Date of Birth	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		Sex: ☐ Male ☐ Female
Home Phone	Ethnicity: ☐ Hispanic/Latino ☐ Other	Race: ☐ African American ☐ Asian ☐ White ☐ American Indian ☐ Other		Preferred Language
Cell Phone	Referring Doctor		Referring Doctor Phone	
Work Phone	Primary Care Physician (PCP)		PCP Phone	
Email		Occupation		

EMERGENCY CONTACT		
Emergency Contact Name	Relationship	
Home Phone	Work Phone	Cell Phone

RESPONSIBLE PARTY (IF OTHER THAN PATIENT, *example: POA, parent of child*)				
Responsible Party Name			Relationship	
Home Phone	Work Phone		Cell Phone	
Address		City	State	Zip
Date of Birth	Social Security #		Sex: ☐ Male ☐ Female	
If patient is a child, lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____ Name of Person (With Whom Child Lives With): _____				

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Atlantic Urology Medical Group and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: _____ **DATE:** _____