Appt Date _____
Date of Birth _____

Patient Registration

Patient Information

Last Name First Name MI Email address

Address City State Zip Code

Home Phone ( ) _____ - _____ Work Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____ SS # ____ - ____ - _____

Gender M☐ F☐ Marital Status: Married☐ Single☐ Divorced☐ Widowed☐

Employer's Name Employer's Address

Emergency Contact Relationship Home Phone Work Phone Cell Phone

_____ _____ ( ) ____ - _____ ( ) ____ - _____ ( ) ____ - _____

How do you learn about us? ☐ Internet ☐ Friend ☐ Family Physician ☐ Provider Directory Other_____

Whom may we thank for referring you? _____

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White
☐ Refused to Report / Unreported ☐ Other Pacific Islander ☐ More than one race

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

Preferred Language

☐ English ☐ Spanish ☐ Italian ☐ Russian ☐ Chinese ☐ Korean ☐ Japanese Other _____

Are you a resident of a: Nursing facility Rehabilitation facility Hospice Admission Date: ____/____/_____

If so, name of facility _____ Phone: ( ) _____ - _____

Address _____

Referring Physician (s) Information

Usual Provider _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Referring Physician _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Primary Care Physician _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Patient Name _____ Date of Birth _____

Primary Insurance Information

Medicare Medicaid Health Insurance Self Pay Worker's Comp No Fault

Policyholder's Name _____ Insurance Name _____

Policyholder's SSN # _____ Claims Address _____

Policyholder's Date of Birth _____ City, State, Zip _____

Relationship to Patient _____ ID # _____ Group # _____

Secondary Insurance Information

Medicare Medicaid Health Insurance Self Pay Worker's Comp No Fault

Policyholder's Name _____ Insurance Name _____

Policyholder's SSN # _____ Claims Address _____

Policyholder's Date of Birth _____ City, State, Zip _____

Relationship to Patient _____ ID # _____ Group # _____

Third Insurance Information

☐ Medicare ☐ Medicaid ☐ Health Insurance ☐ Self Pay ☐ Worker's Comp ☐ No Fault

Policyholder's Name _____ Insurance Name _____

Policyholder's SSN # _____ Claims Address _____

Policyholder's Date of Birth _____ City, State, Zip _____

Relationship to Patient _____ ID # _____ Group # _____

Guarantor Information

Last Name First Name MI Date of Birth Gender

_____

Address City State Zip Code Email address

_____

Home Phone Work Phone Cell Phone Social Security #

_____

Employer's Name Employer's Address

_____

Relationship to Patient _____

Acknowledgement of Financial Responsibility

I hereby authorize Advanced Urology Centers of New York, a division of Integrated Medical Professionals, to release to all insurance companies / carriers above any medical or other information required for processing insurance claims. I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to Advanced Urology Centers of New York, a division of Integrated Medical Professionals, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____

Signature of Patient or Authorized Signature (if over 18 years of age) | Printed name of Patient or Authorized Signature (if patient is under 18 years of age) | Date

Pharmacy Information

Pharmacy Name _____ Phone _____ Fax _____

Address _____ City, State, Zip _____