Northwest Urology LLC

Patient Registration

Patient Name: _____ **Preferred Name:** _____
Last First M.I.

Gender: M F **DOB:** _____/_____/_____ **SSN:** _____-_____-_____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Street Address (if different than mailing): _____

Home Phone: _____ **Mobile Phone:** _____

Work Phone: _____ **Email:** _____

Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Language: _____ **Race:** _____

Ethnicity: ☐ Hispanic or Latino/Spanish ☐ Not Hispanic or Latino ☐ Other

May we send emails possibly containing your private medical information to the email address you provided above? ***Yes No***

May we leave voice messages at your preferred phone number possibly containing your private medical information? ***Yes No***

Would you like to receive automated reminder calls? If you receive the calls via your mobile device, carrier rates may apply. ***Yes No***

Would you like to receive automated text message alerts regarding appointment reminders and more? ***Yes No***

Employer Name: _____

Employer Phone: _____ **Occupation:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Preferred Pharmacy Name: _____ **Location or Phone:** _____

How did you hear about us? ☐ Advertising ☐ PCP ☐ Specialist Dr. ☐ Word of Mouth ☐ Patient ☐ Hospital

☐ Insurance Company ☐ Other (please specify): _____

Emergency Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Mobile Phone:** _____

Spouse (Next of Kin) Name: _____ **DOB:** _____/_____/_____

Home Phone: _____ **Mobile Phone:** _____

(continued on back)

Responsible Party for Minor Children (if applicable):

1) Parent/Guardian Name: _____ **DOB:** _____/_____/_____
Last First M.I.

Relationship to patient: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SSN: _____-_____-_____ **Phone:** _____ **Email:** _____

2) Parent/Guardian Name: _____ **DOB:** _____/_____/_____
Last First M.I.

Relationship to patient: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SSN: _____-_____-_____ **Phone:** _____ **Email:** _____

Insurance Information:

Primary Insurance: _____ **Effective Date:** _____/_____/_____

ID #: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____/_____/_____ **Relationship to patient:** _____

Secondary Insurance: _____ **Effective Date:** _____/_____/_____

ID#: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____/_____/_____ **Relationship to patient:** _____

ASSIGNMENT OF BENEFITS

I hereby assign any medical surgical insurance benefits to Northwest Urology, LLC to allow my provider to obtain payment for services I receive. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for all charges, whether or not paid in part by insurance. I further authorize Northwest Urology, LLC to release financial information to a health insurer in order to obtain payment for services.

RELEASE OF INFORMATION

It is sometimes necessary for Northwest Urology, LLC to provide information regarding a patient's medical or pharmaceutical history and treatment to other medical providers, hospitals, pharmacies, or medical facilities when required for the patient's medical needs, to facilitate treatment, or to verify benefits. It is also sometimes necessary for those providers to request similar information from Northwest Urology, LLC. I give my authorization for such sharing of information.

Patient/Responsible Party Signature: _____ **Date:** _____

Print Responsible Party Name (if other than patient): _____

Relationship Patient: _____