

Patient Name: _____
 DOB: _____
 Age: _____
 Gender: _____

Registration Form

Date: _____ Dr. Name: _____

Patient: _____
 Last Name First Name MI Mr./Ms./Mrs.

Patient Social Security Number: _____

Date of Birth: _____ Race (optional): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail Address: _____

Marital Status: Single Married Divorced Separated Widowed Minor

Employment Status: Full-time Part-time Unemployed Retired Student

Emergency Contact: _____

Relationship: _____ Phone: _____

Referring/Primary Care Doctor: _____ Phone: _____

Referring/Primary Care Doctor Address: _____

Do you have an Advanced Directive (Living Will)? Yes No Interested in Obtaining

INSURANCE INFORMATION

We require a copy of your insurance card in order to submit claims.

Self Pay

Primary Insurance Coverage: _____

Insurance Phone: _____

Claims Address: _____

City: _____ State: _____ Zip Code: _____

Name on ID Card: _____

Subscriber (person who holds the policy): _____

Subscriber Date of Birth: _____ Subscriber Social Security Number: _____

Patient's Relationship to Subscriber: Patient Spouse Dependent Other: _____

Subscriber's Address (if different from patient) _____

City: _____ State: _____ Zip Code: _____

Policy ID Number: _____

Group Number: _____

Subscriber's Employer: _____

Subscriber's Employer Address: _____

City: _____ State: _____ Zip Code: _____

Effective Date of Policy: _____

/SharedID-45

Patient Name: _____
DOB: _____
Age: _____
Gender: _____

Registration Form – Page 2

Date: _____

Secondary Insurance Coverage: _____

Insurance Phone: _____

Claims Address: _____

City: _____ State: _____ Zip Code: _____

Name on ID Card: _____

Subscriber (person who holds the policy): _____

Subscriber Date of Birth: _____ Subscriber Social Security Number: _____

Patient's Relationship to Subscriber: Patient Spouse Dependent Other: _____

Subscriber's Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Policy ID Number: _____

Group Number: _____

Subscriber's Employer: _____

Subscriber's Employer Address: _____

City: _____ State: _____ Zip Code: _____

Effective Date of Policy: _____

AUTHORIZATION

Our primary responsibility is to help our patients experience good health. Payment for services is expected to be paid at the time of service, including co-payments. If you do not pay your co-pay on the date of service, your appointment may need to be rescheduled.

Our billing office will submit all claims to your insurance carrier. Any outstanding balances are due at the time of the first billing.

I authorize the release of medical records or other information necessary to process my claims, as well as payment of medical benefits to Anne Arundel Urology, P.A./Anne Arundel Urological Surgery Center, LLC. I also acknowledge that I am responsible for any missed appointment or cancellation fees incurred.

I, _____, fully understand that I am responsible for payment of services rendered.

Patient Signature (Seal) Date