Urology Institute of the Southbay
Patient Registration Form

Date: _____ (Please Print & Complete in Full) MRN#: _____

PATIENT INFORMATION Social Security #: _____-_____-_____

Last Name: _____ First Name: _____ MI: ____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

Cell Number: (_____)_____-_____

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

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

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

If Patient is a child, lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Name of Person (With Whom Child Lives With): _____

Employer: _____ Occupation: _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: _____-_____-_____

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female Relationship: _____

REFERRED BY:

Referring Physician: _____ Phone:(_____)_____-_____

PCP Physician: _____ Phone:(_____)_____-_____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

PHARMACY INFORMATION

Pharmacy Name: _____

(Name, Street Name & Phone Number, if known)

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 Urology Institute of the Southbay or 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:** _____

UROLOGY INSTITUTE OF THE SOUTHBAY

PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Sharron Nakazawa, Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

PRINT PATIENT'S NAME	**PATIENT MRN NUMBER**
Patient or Legally authorized individual signature	Date Time
Printed Name if signed on behalf of the patient	Relationship to Patient

(Notation, if any, by staff)

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DESCLOSED:

Print Name of person/organization	**Relationship to Patient**
Print name of person/organization	**Relationship to Patient**