Children's Urology Group, PL

PATIENT REGISTRATION

PATIENT'S Last Name: _____ First: _____ Middle: _____
Date of Birth: _____SSN #: _____ Other Name: _____
Address: _____
Street, Apartment # City State Zip
County: _____Home Telephone #: (___)_____ Sex: _____
Emergency Notification (other than parent) Name: _____ Phone (___)_____
Relationship: _____ **REFERRING DOCTOR**: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian_____
Date of Birth_____ SSN _____
Address_____ ___
City, State, Zip_____
Home Phone (___) _____
Employer _____
Work Phone (___)_____
Address _____
City, State, Zip _____
Occupation _____

Father/Guardian_____
Date of Birth _____SSN _____
Address _____
City, State, Zip_____
Home Phone (___)_____
Employer _____
Work Phone (___)_____
Address_____
City, State, Zip _____
Occupation _____

PRIMARY INSURANCE (Please provide card to be copied):

Company Name_____ Through Employer ___ Yes ___ No
Mailing Address _____
Insured's Name _____ **Group Name** _____
Policy Number _____ Group Number _____ SSN_____

SECONDARY INSURANCE (Please provide card to be copied):

Company Name_____ Through Employer ___ Yes ___ No
Mailing Address _____
Insured's Name _____ **Group Name** _____
Policy Number _____ Group Number _____ SSN_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION: Any parent or legal guardian (regardless of marital status) who brings in a minor for treatment is, and hereby agrees to be, responsible for paying the minor's account in full at the time of the visit.

- if a contractual agreement exists between Children's Urology Group and a third party payor (i.e. insurance, Medicaid, etc.), that I am responsible for all deductibles and co-pays at the time of the visit as prescribed by my health coverage,
- I am responsible for any costs incurred in the collection of this account in case of default, including reasonable attorney fees and/or court costs,
- **I hereby assign, transfer and convey payment and authorize said payment to be made directly to Children's Urology Group or the individual doctor providing services for any hospital/surgical benefits, sick benefits, injury benefits, due because of liability of a third party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for discharge or completion of all outstanding obligations related to treatment of this patient,**
- I authorize Children's Urology Group and/or the physician to furnish my insurance company and/or responsible third party payor, or their representatives, any medical information necessary to process claims from this office.
- I authorize Children's Urology Group to release my child's SSN (Social Security Number) to hospitals, outpatient facilities, radiology facilities or labs for scheduling and reporting purposes.

SIGNED: _____RELATIONSHIP: _____DATE: _____