Valley Urologic Associates

VALLEY UROLOGIC ASSOCIATES

Patient Registration Form

Patient Information

Last Name		First Name	MI	DOB	Age	Sex	Marital Status
Street Address			Social Security Number				
City	State	ZIP	Home Phone		Work Phone		Cell Phone
Employer Name			Occupation				
Street Address			City		State	ZIP	Phone Number
Primary Care Doctor			Phone Number				
Street Address			City		State	ZIP	FAX

Responsible Party

Name		Relationship	Date of Birth			
Street Address			Social Security Number			
City	State	ZIP	Home Phone		Work Phone	Cell Phone
Employer Name	Street Address		City		State	ZIP	Phone Number

Emergency Contact

Name	Relationship to Patient	Home Phone	Cell Phone
Street Address		Employer Name	

Primary Insurance

Name			ID/Policy Number		Group Number
Address			Insurance Effective Date		Copay Amount
City	State	ZIP	Phone Number	Policy Holder	DOB

Secondary Insurance

Name			ID/Policy Number		Group Number
Address			Insurance Effective Date		Copay Amount
City	State	ZIP	Phone Number	Policy Holder	DOB

I hereby authorize the release of any information required in the course of my assessment or treatment. I hereby authorize payment of medical benefits directly to VUA, LLC d.b.a. Valley Urologic Associates. I do understand that I am financially responsible for non-covered services, and I am fully responsible should insurance coverage not exist. Further, I understand that I am responsible for all charges incurred in the collection of this account and will pay all fees involved should this account be placed with a collection service.

Signature _____ Date _____

Valley Urologic Associates

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