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
Email Address		Occupation				
Employer Name		Race		Ethnicity		Preferred Language
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
Emergency Contact Email Address		Other Contact Information	

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 ACHO, PLC VUA Division 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 _____