UrologyAustin

PATIENT REGISTRATION – DEMOGRAPHICS

Assigned UA Physician

PATIENT INFORMATION

Last Name	First Name	M.I.	Nickname

SSN	Sex ☐ Female ☐ Male	Date of Birth	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race/Ethnicity ☐ I decline to answer ☐ African-Amer. ☐ Asian ☐ Caucasian ☐ Hispanic or Latino ☐ Native Amer. ☐ Pacific Islander ☐ Other

Preferred Language ☐ English ☐ Spanish ☐ Other:

Street Address	Apt #

City	State	Zip

Preferred Contact: ☐ Home # ☐ Work # ☐ Cell # ☐ Email	Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Email Address

Referring Physician	Referring Physician Phone ( )	Primary Care Physician	Employer Name ☐ n/a

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient: ☐ Spouse/Partner ☐ Friend ☐ Parent ☐ Other:	Phone ☐Home ☐Cell ☐Work ( )	Phone ☐Home ☐Cell ☐Work ( )

GUARANTOR (Financially-responsible party)

Name (☐ same as patient)	Relationship to Patient: ☐ Parent/Guardian ☐ Power of Atty. ☐ Other:	Phone ☐Home ☐Cell ☐Work ( )	Phone ☐Home ☐Cell ☐Work ( )

Street Address	Apt #

City	State	Zip

INSURANCE INFORMATION

Primary Insurance ☐ no insurance or wish to self-pay	*Secondary* Insurance ☐ none
☐ Private Policy ☐ Group Policy (Employer) ☐ TriCare (ChampUS) ☐ Medicare (Part B) ☐ Medicaid ☐ Indemnity Plan ☐ Worker's Comp ☐ Other	☐ Private Policy ☐ Group Policy (Employer) ☐ TriCare (ChampUS) ☐ Medicare (Part B) ☐ Medicaid ☐ Indemnity Plan ☐ Worker's Comp ☐ Other
Insurance Name/Plan	Insurance Name/Plan
Insurance/Member ID #	Insurance/Member ID #
Group # ☐ n/a	Group # ☐ n/a
Claim # ☐ n/a	Claim # ☐ n/a
Subscriber Name ☐ patient = subscriber	Subscriber Name ☐ patient = subscriber
Subscriber DOB / Subscriber SSN	Subscriber DOB / Subscriber SSN

OTHER INFORMATION

Are you a resident of a nursing home facility? ☐ Yes ☐ No (If Yes, patient must be accompanied by an informed caregiver)	Are you registered for Home Health Care? ☐ Yes ☐ No
Facility Name	What is your preferred pharmacy for prescriptions?
Facility Phone ( )	Do you have a mail order or second pharmacy for prescriptions? Please provide name.

Patient/Guardian Signature: _____ Date Signed: _____