



PATIENT REGISTRATION FORM
PLEASE PRINT & COMPLETE IN FULL

CHART NUMBER _____ YOUR GAINESVILLE UROLOGY DOCTOR _____

PATIENT INFORMATION

TODAY'S DATE _____

SOCIAL SECURITY #: _____ - _____ - _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

RESIDENCE ADDRESS: _____

MAILING ADDRESS (if different from residence) _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ - _____ WORK PHONE: (_____) _____ - _____

DATE OF BIRTH: ____/____/____ AGE: ____ SEX: (circle) Female or Male

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

Optional: 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) _____

- In the event surgery is recommended patients may elect the location of their choice. Gainesville Urology Ambulatory Surgery Center is owned and operated by Gainesville Urology Physicians.

INSURANCE INFORMATION (we cannot file your insurance without this information)

PRIMARY INSURANCE: _____ COPAY: Y or N AMOUNT: _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: ____/____/____ POLICY HOLDER'S SOCIAL SECURITY # _____

IF INSURANCE IS THROUGH AN EMPLOYER, GIVE EMPLOYER NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____ COPAY: Y or N AMOUNT: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: ____/____/____ POLICY HOLDER'S SOCIAL SECURITY # _____

IF INSURANCE IS THROUGH AN EMPLOYER, GIVE EMPLOYER NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

PATIENT EMPLOYER INFORMATION

CURRENTLY EMPLOYED?: Y or N **OR** STUDENT FULL-TIME _____ PART-TIME _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAIN OFFICE PHONE: (_____) _____ - _____ OCCUPATION: _____

(More on back)

PATIENT NAME

LAST NAME: _____

FIRST NAME: _____ **MI:** _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

SOCIAL SECURITY #: _____ - _____ - _____

RESPONSIBLE PARTY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ - _____ WORK PHONE: (_____) _____ - _____

DATE OF BIRTH: ____/____/____ SEX: (circle) Female or Male RELATIONSHIP: _____

RESPONSIBLE PARTY EMPLOYER: _____

WHO REFERRED YOU TO GAINESVILLE UROLOGY?

WHICH DOCTOR REFERRED YOU TO GAINESVILLE UROLOGY _____ PHONE: (_____) _____ - _____

PRIMARY CARE PHYSICIAN NAME (if different from above): _____

PHONE: (_____) _____ - _____

IN CASE OF EMERGENCY (YOU AUTHORIZE US TO CONTACT THESE PERSONS)

RELATIVE/FRIEND: _____

HOME PHONE: (_____) _____ - _____ WORK PHONE:(_____) _____ - _____

RELATIONSHIP: _____

EMERGENCY CONTACT WHO DOES NOT LIVE IN YOUR HOUSEHOLD:

NAME: _____

HOME PHONE: (_____) _____ - _____ WORK PHONE:(_____) _____ - _____

RELATIONSHIP: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHONE: (_____) _____ - _____