

Last Name _____ First _____ MI _____ Age _____

Address _____ Zip _____ City _____ State _____

Alternative address for mailing (Optional) _____

Area code - Home Phone: _____ Area code - Work phone: _____

Alternate Phone number for calls (Optional) _____

I wish to receive reminder/confirmation calls for appointments ? YES NO

Social Security # _____ Date of Birth _____ Gender: Male Female

Marital Status: Single Married Divorced Widowed Separated Ethnicity (Race) _____

Parents' Names (if patient is minor) _____ Child lives with: both parents mother father other

Employer _____ Occupation _____

Family Doctor _____ Referred by _____

Reason for visit _____

May we leave a message at your home with other residents? [] Yes [] No

If you have an answering machine, may we leave a message on the machine? [] Yes [] No

Who may we talk to about your medical concerns: _____

Relationship: _____ Home Phone _____ Work Phone _____

Notify in Case of Emergency:

Last Name _____ First _____

Relationship _____ Home phone _____ Phone #2 _____

Payment Authorization/General Consent for Treatment

Medicare and Medicaid: I authorize the release of any medical or other information needed to process any claims on my behalf. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Southwest Urology, Inc for services rendered.

All other Insurance Companies an/or Third Party Payers: I HEREBY AUTHORIZE, Southwest Urology, Inc and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and other health care professionals and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Southwest Urology, Inc for rendering services. I authorize the release of any medical or other necessary information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I understand that filing a claim with my insurance company or other third party payers, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Southwest Urology, Inc to me or to the patient as indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation and /or claims due to personal injury, accident/illnesses.

General Consent to Treatment: Having come to Southwest Urology for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize the Physicians and other staff members involved in my care to administer such diagnostic procedure, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment. Right to refuse treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Signature

Date Signed

Southwest Urology, Inc.
Registration Form

Date: _____