

**THE CENTER FOR MEN'S AND WOMEN'S UROLOGY, LLC**  
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**PATIENT REGISTRATION**

**Primary Care Physician?** \_\_\_\_\_ **Who referred you to our office?** \_\_\_\_\_

Patient Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ May we contact you at this number? Yes \_\_\_\_\_ No \_\_\_\_\_

Work Phone:(\_\_\_\_) \_\_\_\_\_ May we contact you at this number? Yes \_\_\_\_\_ No \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ May we contact you at this number? Yes \_\_\_\_\_ No \_\_\_\_\_

Email address \_\_\_\_\_ Preferred method of contact: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Language Spoken \_\_\_\_\_

Employer Address \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Spouse \_\_\_\_\_ Telephone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Spouse Employer \_\_\_\_\_

**EMERGENCY CONTACT: (NOT LIVING WITH YOU)**

Name: \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_ Relationship to Patient? \_\_\_\_\_

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**INSURANCE INFO:**

**PRIMARY INSURANCE:** \_\_\_\_\_ Subscriber/Insured DOB \_\_\_\_\_

Policy or I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber/Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber/Insured Social Security #: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Subscriber/Insured DOB: \_\_\_\_\_

Policy or I.D.#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber/Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber/Insured Social Security #: \_\_\_\_\_

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**PREFERRED PHARMACY:** \_\_\_\_\_ Address: \_\_\_\_\_ Phone # \_\_\_\_\_

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*I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_