

PATIENT REGISTRATION FORM

Today's date: _____ Doctor: _____

Code: _____ Referring Doctor: _____

Patient Name: _____
Last First Middle

Address: _____
Street or P.O. Box City State Zip Code

Telephone Numbers: Home (____)____-____ Work (____)____-____ Cellular/Pager (____)____-____

Social Security Number: _____ Date of Birth: _____

Patient Employment Status: (please circle one) Full-time Part-time Retired Unemployed Student

Patient Employer: _____

Marital Status: (please circle one) Married Single Divorced Widowed Patient Sex: MALE FEMALE

Name of Spouse: _____

Spouse Employment Status: (please circle one) Full-time Part-time Retired Unemployed

Name of Spouse's Employer: _____ Work phone (____)____-____

Spouse Social Security Number: _____ Date of Birth: _____

Do you currently have medical insurance? ____yes ____no

Is your insurance provided by your employer? ____yes ____no

Is your insurance provided by spouse's employer? ____yes ____no

RESPONSIBLE PARTY INFORMATION

Responsible Party: (please circle one) Self Spouse Mother Father Other: _____

If responsible party is someone other than the patient or the patient's spouse, please fill out section below.

Name: _____ Date of birth: _____

Address: _____ SSN: _____

Telephone Numbers: Home (____)____-____ Work (____)____-____ Cellular/Pager (____)____-____

Employer: _____

I/we hereby guarantee payment of all charges and finance charges incurred for the account of the above named patient. I/we understand that a finance charge of 1.5% per month may be applied to the account balances that are unpaid 60 days after the first billing and that this is an annual rate of 18%. I/we also understand that I will be responsible for the cost incurred for collecting past due balances, including reasonable attorney fees. I/we authorize Franklin Urological Associates, P.C. to convey to the insurance company, or their representative any and all information it possess relative to the services provided. I/we hereby authorize and direct any insurance company or carrier to deduct and pay direct to Franklin Urological Associates, P.C. any and all benefits due me or my dependents for services rendered. I/we understand that it is my/our responsibility to give Franklin Urological Associates, P.C. correct and updated insurance information upon every visit.

Date: _____ Patient Signature: _____ Responsible Party: _____