UROLOGY ASSOCIATES OF MS
UROLOGICAL SURGERY ASSOCIATES PLLC
PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: _____

Name: _____

Mailing Address: _____

City/State/Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Account #: _____

Date of Birth: _____

Age: _____

Social Security #: _____

Referred by: _____

Marital Status: Married ( ) Single ( ) Other ( )

Sex: Male ( ) Female ( )

Email _____

MUST BE COMPLETED

RESPONSIBLE PARTY INFORMATION (INSURED PERSON)

(Only Complete If Different From Patient)

Name: _____

Mailing Address: _____

City/State/Zip: _____

Social Security#: _____

Date of Birth: _____

Employer: _____

Work Phone: _____

Patient's Employer: _____

Work Phone: _____

EMERGENCY CONTACT INFORMATION

In Case of Emergency Notify: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

INSURANCE INFORMATION

(If insurance cards are available please present to front desk and omit this section)

Primary Insurance: _____

I.D. Number: _____ Group: _____

Mailing Address: _____

City/State/Zip: _____

Name/Policy Holder: _____

Social Security #: _____

Date of Birth: _____

Secondary Insurance: _____

I.D. Number: _____ Group: _____

Mailing Address: _____

City/State/Zip: _____

Name/Policy Holder: _____

Social Security #: _____

Date of Birth: _____

Payment of Benefits and Medical Release Authorization:

I authorize treatment of the patient named above and agree to pay all fees and charges billed by Urology Associates of MS, P.A. (Dr.Mark Condon, Dr. Avinash Gulanikar and Dr. Sujith K. Reddy). I request that payment of authorized Medicare, Medicaid or third party insurances be made to Urology Associates of MS, P.A. or one of its physicians if assignment is accepted, in which case I agree to pay any deductible, co-payment or non-covered charges. If assignment is not accepted,then I agree to pay the entire amount due. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or the Division of Medicaid or their Fiscal Agent or any third party insurance any information needed to determine these benefits. (A copy of this assignment is as valid as the original.)

Signature: _____ Date: _____

Release for Destruction of X-rays:

I understand that my x-rays will be destroyed with the exception of special circumstances after (5) five years.

Signature: _____ Date: _____

UROLOGY ASSOCIATES OF MISSISSIPPI