

Seattle Urological Associates

PATIENT REGISTRATION – Please Print Clearly

PATIENT NAME _____ Home Phone _____
Last First Middle Okay to Contact

Patient Address _____
Street City State Zip

Patient Cell: _____ Patient Email: _____
 Okay to Contact Okay to Contact

Responsible Party (if different from above) _____

Patient Date of Birth _____ Age _____ Sex: Male _____ Female _____

Social Security # _____ Occupation _____

Employer _____ Business Phone _____
 Okay to Contact

Name of Spouse _____ Occupation _____

Referring Doctor _____ Phone _____

Primary Doctor _____ Phone _____

Insurance Information

PRIMARY INSURANCE _____

Subscriber Name _____ Self _____ Spouse _____ Parent _____

Subscriber Birthdate _____ Member ID# _____ Group # _____

SECONDARY INSURANCE _____

Subscriber Name _____ Self _____ Spouse _____ Parent _____

Subscriber Birthdate _____ Member ID# _____ Group # _____

In case of emergency, local friend or relative to be notified.

Name _____ Phone _____

Relationship to Patient _____

I understand that my insurance(s) will be filed, as a courtesy, but I remain solely responsible to Seattle Urological Associates for all charges incurred. I hereby authorize Seattle Urological Associates and/or its representative to release any and all information necessary to process my insurance claim(s). I hereby authorize my insurance company(s) to pay benefits directly to Seattle Urological Associates. I hereby authorize Seattle Urological Associates to release my medical records to other physicians who may also provide medical care to me.

Signature _____ Date _____

How did you hear about us? Internet Friends Physician Other