Urological Clinic of Valdosta, P.C.

3294 North Oak Street Ext. · Valdosta, GA 31605 · 229-241-1188

Patient Registration Form

Patient: Last Name_________________________ First_______________________ Middle___________________

Date of Birth ___________ Social Security# __________________ Email Address:__________________________

Race (choose): African American/American Indian/Asian/Caucasian/Hawaiian / Other / Unknown / DECLINED

Ethnicity (chose): Hispanic or Latino / NOT Hispanic or Latino / DECLINED SEX: Male / Female

MAILING Address: Street____________________________ City ______________ State _______ ZIP _________

(If different) PHYSICAL Address:____________________________City______________State______ZIP_______

Telephone: Home (___)_____-________ Cell (___)_____-_______ Work (___)_____-_______Ext___________

Preferred Language: □ English □ Other _____________ Marital Status: ________________________________

Place of Employment: ___________________________ Occupation: ___________________________________

How do you want to receive appointment reminders (circle one or more): EMAIL TEXT PHONE

□ **Spouse** □ **Parent** **or** □ **Guardian** **PREFERRED PHARMACY ____________________ City____________**

Name _____________________________ D.O.B. ________ SSN ________________ Cell (___)_____-________

Employer ____ Work (___)____-______ Ext ____________________

Employer Address _____________________________ City ______________ State ________ ZIP ___________

Insurance

Primary Insurance _______________________________ Policy# _______________ Group# _______________

Policyholder: Name ______________________________ D.O.B. ___________ SSN _______________________

Secondary Insurance ____________________________ Policy# _______________ Group# _______________

Policyholder: Name ______________________________ D.O.B. ___________ SSN _______________________

Person Responsible For Payment, If Not Above

Name __________________________ Address ____________________________ Phone (___)____-_________

Additional Emergency Contacts Other Than Listed Above

Name _________________________________ Relationship _________________ Phone (___)____-__________

Name _________________________________ Relationship ________________ Phone (___)____-__________

I consent to treatment necessary for the care of the above named patient. Furthermore, I certify that the information furnished above is accurate, and I agree to notify the practice if any of the furnished information should change during the course of treatment. I understand that the patient may refuse treatment to the extent permitted by law. Also, it is understood that when refusal of treatment by the patient, or legally authorized representative, prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated by the provider upon reasonable notice.

I authorize the release of all medical records to the referring and family physicians, to my insurance company, and to myself if applicable. I allow fax transmittal of my records, if necessary. This authorization is subject to revocation at any time by providing a written request.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. If I am insured by a plan in which the physicians are preferred providers, I am responsible for paying any deductible/coinsurance/copay that may apply for my visit. Additionally, I understand that a rebilling fee will be applied to those accounts that are 30 days or more past dues and that Urological Clinic of Valdosta, P.C. reserves the right to take appropriate collection action of seriously delinquent accounts. I acknowledge understanding of the financial policies of the practice and agree to uphold my financial obligations as described.

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Patient Signature/ Parent or Guardian if patient is a minor Date