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Urology & Urological Surgery

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Registration Form (PLEASE PRINT)

Patient Information

Name:_____ Social Security # _____
Last Name First Name Initial

Street Address:_____City:_____

State: _____ Zip _____ Home Phone Number:_____Cell Phone: _____

Male ☐ Female ☐ Date of Birth: _____ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Patient Employer/School: _____ Phone Number: _____

Street Address: _____ City:_____

State: _____ Zip _____ Who referred you? _____

Who is your internist or primary care physician?_____

In case of emergency, who should we notify? _____ Phone:_____

Primary Insurance

Insurance
Company:_____Address:_____

Insurance Co. Phone Number: _____ ID Number: _____ Group Number:_____

Person responsible for Account_____ Relationship to Patient:_____
Last Name First Name Initial

Street Address (if different than patient's): _____

City:_____ State: _____ Zip _____ Social Security # _____Date of Birth: _____

Additional Insurance

Insurance
Company:_____Address:_____

Insurance Co. Phone Number: _____ ID Number: _____ Group Number:_____

Person responsible for Account_____ Relationship to Patient:_____
Last Name First Name Initial

Street Address (if different than patient's): _____

City:_____ State: _____ Zip _____ Social Security # _____ Date of Birth: _____

(1)I authorize the release of any medical information necessary to process my insurance claim(s). (2) I authorize and request payment of medical benefits directly to Alan Schrager, MD. (3) I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. (4) I agree that a photocopy of this form may be used in lieu of the original. (5) I agree to pay all chargers not covered by my insurance carrier(s). These charges include but are not limited to deductibles and copayments of my insurance policy.

Signature Date