

Middle Tennessee Urology Specialists

Patient Registration Form

(Please Print & Complete in Full)

Date: _____

MRN#: _____

Physician's Name: _____

PATIENT INFORMATION

Social Security #: _____ - _____ - _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ - _____ Home Cell Work

Secondary Phone Number: (_____) _____ - _____ Home Cell Work

Date of Birth: ____/____/____ Age: ____ Sex: Male Female

Marital Status: Single Married Widowed Divorced Separated

Race: African American Asian Caucasian Hispanic Native American Other

RESPONSIBLE PARTY (IF PATIENT IS A CHILD OR DISABLED)

Social Security #: _____ - _____ - _____

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (_____) _____ - _____ Work Number: (_____) _____ - _____

Date of Birth: ____/____/____ Sex: Male Female Relationship: _____

Responsible Party Employer: _____

PATIENT EMPLOYER INFORMATION

Employed: Yes No Student: Full-Time Part-Time

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Main Office Phone: (_____) _____ - _____ Occupation: _____

INSURANCE INFORMATION (We require a copy of your card)

Primary Insurance: _____ Copay: Yes No Amount: \$ _____

Policy Holder Name: _____ Relationship: _____

Date of Birth: ____/____/____ Percentage Plan Pay (example 80%): _____

Insurance Address: _____ Phone: (_____) _____ - _____

City: _____ State: _____ Zip: _____

If Insurance is through an Employee, please give Employer name: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION (We require a copy of your card)

Primary Insurance: _____ Copay: Yes No Amount: \$ _____
Policy Holder Name: _____ Relationship: _____
Date of Birth: ____/____/____ Percentage Plan Pay (example 80%): _____
Insurance Address: _____ Phone:(____)____ - _____
City: _____ State: _____ Zip: _____
If Insurance is through an Employee, please give Employer name: _____
Policy Number: _____ Group Number: _____

REFERRED BY:

Referring Physician: _____ Phone:(____)____ - _____
If not referred by a physician, how did you hear about our office:
Web Page Yellow Pages Friend/Family Radio Insurance Directory
TV Emergency Room Newspaper Other: _____

PRIMARY CARE PHYSICIAN NAME (if different from above)

PCP Physician: _____ Phone:(____)____ - _____

IN CASE OF EMERGENCY

Relative/Friend: _____
Home Number: (____)____ - _____ Work Number: (____)____ - _____
Relationship: _____

EMERGENCY CONTACT (that does not live in your Household):

Name: _____
Home Number: (____)____ - _____ Work Number: (____)____ - _____
Relationship: _____

PHARMACY INFORMATION

Pharmacy Name: _____
Phone Number: (____)____ - _____ Fax Number: (____)____ - _____
(If Known)

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Middle Tennessee Urology Specialist or insurance company to release any information required to process my claims.

PATIENT SIGNATURE: _____ **DATE:** _____