



# UROLOGY SPECIALISTS *of* SOUTHERN CALIFORNIA

## Patient Registration Form

(Please Print & Complete in Full)

Date: \_\_\_\_\_

### PATIENT INFORMATION

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced  Separated

Primary Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Secondary Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_

If Patient is a child, lives with:  Both Parents  Mother  Father  Other: \_\_\_\_\_

Name of Person (With Whom Child Lives With): \_\_\_\_\_

### RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female Relationship: \_\_\_\_\_

### REFERRED BY:

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PCP Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### IN CASE OF EMERGENCY

Relative/Friend: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### PHARMACY INFORMATION

Pharmacy Name: \_\_\_\_\_

(Name, Street Name & Phone Number, if known)

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize USSC and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_