

Southwest Urology Associates

Patient Registration Form

Acct. No. _____

SUA Physician _____

Patient Information

First Name _____ MI _____ Last Name _____

Date of Birth ____/____/____ Male Female Social Security No. _____

Marital Status: Single Married Divorced Separated Widowed - Email Address _____

Address _____ Apt./Lot # _____

City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____ Business Phone _____

Patient's Employer _____ Occupation _____

Employer's Address _____

Reason or Health Concern that brings you in today _____

Name of Referring Physician _____ Office Phone _____

If not Referred – How did you hear about our office?
 Insurance Plan Hospital Referral System Family/Friend Yellow Pages Internet Search Other: _____
(please specify)

Spouse/ Other Information

Name _____ SS # _____ Date of Birth ____/____/____

Employer _____ Address _____ Work Phone _____

Emergency Contact Information

Name _____ Relationship to Patient _____

Home Phone _____ Alternate Phone _____

Insurance Information

(please present your current insurance card(s) to the front desk personnel upon check-in)

Primary Insurance Carrier		Secondary Insurance Carrier	
Policy Holder's Name	Relationship to Patient	Policy Holder's Name	Relationship to Patient
Policy Holder's SS#	Date of Birth	Policy Holder's SS#	Date of Birth

Consent for Treatment

I hereby authorize the physicians of Southwest Urology Associates or their designee(s) to perform examinations, procedures and/or treatments, as they may in their professional judgment deem necessary or beneficial. I understand that specific procedures may require an additional consent form and that I will be presented with the additional consent form should it be necessary. I acknowledge that no guarantees have been made as to the result of such examination or treatment on my condition. I understand my right to participate and make decisions concerning my health care, including the right to refuse medical or surgical treatment.

 Patient's or Authorized Representative's Signature

 Relationship to Patient

 Date