ADULT REGISTRATION FORM: Please complete the entire registration form.

Physician you are here to see: __________________

Patient's Name: ____ **Home Phone#:** _______________________
Last First Middle

Cell phone #: _________________________

Street Address: _______________________________________
City: ________________ State: _______Zip Code: __________ **Work Phone #:** ________________________

Email address: ____________________________

Patient Social Security#: ____________________ Patient's Sex: Male Female

Patient Date of Birth: _______________________ Patient Marital Status: M S D W

Employer: __________________Occupation: ________________Address: ______________________

Spouse's Full Name: ______________________ Contact #: ________________
Emergency Contact: ______________________ Contact #: ________________ Relationship: ____________

Primary Care Doctor: ________________________ Phone: ______________________Address: ____________________________

Doctor who Referred you (if different from primary): ______________ Phone: _____________ Address: _______________________

Pharmacy Name: __________________________ Town:___________________ Phone#:_________________

INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)
Primary Insurance: ____

Policyholder's name (insured's name): _______________________ Date of Birth: __________________

Sex: Male Female Social Security #:___________________ Employer: _____________________

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: ______________________________ Policy Number: _______________________________

Secondary Insurance: ____

Policyholder's name (insured's name): _______________________ Date of Birth: __________________

Sex: Male Female Social Security #:___________________ Employer: _____________________

Patient's relationship to insured (please select): Self Spouse Child Other/Dependent

Group Number: ______________________________ Policy Number: _______________________________

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology for any service furnished to me by GSU's physicians. I authorize Garden State Urology to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary. I further understand that if GSU incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying those fees.

Signature: ____ **Date:** _________________