ADULT AND PEDIATRIC UROLOGY GROUP: PEDIATRIC REGISTRATION FORM

Please complete the entire registration form. Thank you for your time and patience.

Patient's Name: _____ Home Phone#:
Last First Middle _____
Street Address: _____ Cell #: _____
City: _____ State: _____ Zip Code: _____

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

Patient's Date of Birth:_____

Parent Information:
Mother's Name: _____ Father's Name: _____
Employer's Name: _____ Employer's Name: _____
Employer's Address: _____ Employer's Address: _____
Work Number: _____ Work Number: _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

Pediatrician Name: _____

Address: _____ City_____ State_____ Phone # _____

Referring Doctor (if different from Pediatrician) _____

Address: _____ City_____ State_____ Phone #:_____

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 Information:

Name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #:_____ Employer: _____

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

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Secondary Insurance: _____

Policyholder's Information:

Name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #:_____ Employer: _____

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

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Adult and Pediatric Urology Group, for any service furnished to me by APU's physicians. I authorize Adult and Pediatric Urology Group 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.

Signature: _____ **Date:** _____