Virginia Urology

Patient Registration

Date: _____

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Primary Contact Number (_____) _____ Alternate Contact Number (_____) _____

Date of Birth _____/_____/_____ Marital Status _____ Sex: Male Female

Social Security Number _____-_____-_____ E-Mail Address _____

Race _____ Ethnicity _____ Preferred Language: _____

Employment Status: (circle one) Retired Full time Part time Unemployed Self-Employed Student

Occupation _____ Employer _____

Emergency Contact Person _____ Relationship _____ Telephone (_____) _____

May we release medical information to your emergency contact person? (circle one) Yes No

☐ Responsible Party (if different from patient) ☐ Court Appointed Guardian

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Primary Contact Number (_____) _____ Alternate Contact Number (_____) _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____ Sex: Male Female

Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full time Part time Unemployed

Occupation _____ Employer _____

Medical Information

Referring Physician _____ Address/Phone _____

Primary Care Physician _____ Address/Phone _____

Pharmacy _____ Phone Number (_____) _____

Is this appointment Workman's Compensation: Yes No Claim # _____

Insurance Information

Primary Insurance _____ Subscriber's Name _____

Relationship to Policyholder (circle One) Self Spouse Child Other Subscriber's Date of Birth _____/_____/_____

Policy ID # _____ Group # _____

Secondary Insurance _____ Subscriber's Name _____

Relationship to Policyholder (circle one) Self Spouse Child Other Subscriber's Date of Birth _____/_____/_____

Policy ID # _____ Group # _____

☐ **Insurance information provided:** I hereby authorize Virginia Urology/Urosurgical Center of Richmond to release necessary medical information to my insurance company (ies). I further authorize direct payment to the above entities from the above listed companies. I understand that I am responsible for obtaining referrals, if necessary, and paying any co-payments, coinsurance, or deductibles required by my Plan. I also understand that I may be responsible for the full amount in event of non-coverage determined by my Plan. If my account is not paid when due, I further agree to pay collection expenses of 25% of the balance plus interest accrued after 90 days at 1.5% monthly.

☐ **No insurance information provided:** I agree to pay in full by cash, check, credit card or money order at or before the date of service, unless I qualify for financial assistance. If my account is not paid when due, I further agree to pay collection expenses and or attorney fees in the amount of 25% of the balance due, plus interest of 1.5% per month on any balance outstanding for 90 or more days.

Service will be provided only if financial arrangements are made at or before the time of service.

Patient/Guardian Signature: _____ Date _____