Patient Registration Form

(Please Print & Complete in Full)

SKYLINE UROLOGY

PATIENT INFORMATION

Social Security Number		Email Address
First Name	MI	Last Name
Address		
City	State	Zip

Date: _____

Date of Birth: _____/_____/_____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Number: (___)_____-_____ **Work Number:** (___)_____-_____ **Cell Number:** (___)_____-_____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Ethnicity: _____ **Preferred Language:** _____

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, 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 Skyline Urology 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:** _____