104-PATIENT REGISTRATION FORM

Pikes Peak Urology, PC

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI Nickname

Date of Birth _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____ Preferred Pharmacy _____

Primary Phone ( )_____ May we leave a message? (circle) YES / NO

Secondary Phone ( )_____ May we leave a message? (circle) YES / NO

Work Phone ( )_____ OK to call work? (circle) YES / NO

Patient's Employer_____

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone( )_____ Secondary Phone( )_____ Relationship_____

Ethnicity
☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Declined/Undetermined

Race:
☐ 01-Black, African American
☐ 02-Asian
☐ 03-White
☐ 08-American Indian, Alaska Native
☐ 09-Native Hawaiian, Other Pacific Islander
☐ 99-Declined/Undetermined

Preferred Language:
☐ EN-English
☐ ES-Spanish
☐ FR-French
☐ ZH-Chinese
☐ VI-Vietnamese
☐ KO-Korean
☐ Other (please specify) _____

Primary reason for today's visit_____

Primary Care Physician_____ Referring Physician_____
Last First Last First

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group #_____

Name of Policy Holder _____ SSN _____ Date of Birth _____

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

Secondary Insurance _____ Policy #/ID _____ Group #_____

Name of Policy Holder _____ SSN _____ Date of Birth_____

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) **Working-Aged** **ESRD** **Auto/Med/No Fault Liability** **Workers Comp** **Federal Black Lung** **Veterans Affairs** **Disability** **Other Liability**

If you do not have insurance, have you applied for government assistance? (circle) YES NO If yes, provide social worker's information.

Social Worker's Name_____ Phone ( )_____

Office Use Only INITIAL_____ DATE_____