PATIENT REGISTRATION

DATE OF FIRST VISIT: ____/____/____ [ ] Queens Village [ ]Melville

YOUR NAME (Print): _____ HOME PHONE: _____
LAST FIRST M.I. WORK PHONE: _____
BIRTH DATE: ____/____/____ AGE: _____ SS#: _____ CELL PHONE: _____

ADDRESS : _____ SEX: **[ ]** MALE **[ ]** FEMALE

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: **[ ]** MARRIED **[ ]** SINGLE **[ ]** DIVORCED **[ ]** WIDOWED

EMAIL ADDRESS_____

YOUR PRIMARY PHYSICIAN (PCP): _____ Tel.: _____

SPOUSE'S NAME (Print): _____ SPOUSE'S CONTACT #: _____
LAST FIRST M.I.

YOUR OCCUPATION: _____ YEARS IN OCCUPATION: _____

YOUR EMPLOYER NAME:_____ DEPT: _____

YOUR EMPLOYER ADDRESS:_____

YOUR EMPLOYER PHONE #:_____ PERSON HANDLING BENEFITS: _____

SPOUSE'S OCCUPATION: _____ YEARS IN OCCUPATION: _____

SPOUSE'S EMPLOYER NAME:_____ DEPT: _____

SPOUSE'S EMPLOYER ADDRESS:_____

SPOUSE'S EMPLOYER PHONE:_____ PERSON HANDLING BENEFITS: _____

IN CASE OF EMERGENCY PLEASE PROVIDE 2 CONTACT NUMBERS (In order of priority):

NAME	PHONE NUMBER	RELATIONSHIP

UROLOGY℠

INSURED'S NAME (Print): _____ Home Phone: _____
If under someone else's plan LAST FIRST M.I.

BIRTH DATE: _____/_____/_____ AGE: _____ SS#: _____ Work Phone: _____

ADDRESS: _____

Cell Phone: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: **[ ]** SELF **[ ]** SPOUSE **[ ]** CHILD **[ ]** OTHER

PRIMARY INSURANCE CARRIER: _____ CIRCLE TYPE: PPO / POS / HMP / MEDICARE / MEDICAID

PRIMARY GROUP ID #: _____ PRIMARY INSURANCE POLICY #: _____

SECONDARY INSURANCE CARRIER: _____ CIRCLE TYPE: PPO / POS / HMP / MEDICARE / MEDICAID

SECONDARY GROUP ID #: _____ SECONDARY INSURANCE POLICY #: _____

REFERRED BY: **[ ]** DOCTOR _____ **[ ]** Relative **[ ]** Friend **[ ]** Radio Show

[ ] Insurance Book **[ ]** Yellow Pages **[ ]** Print Ad **[ ]** Website

PLEASE READ – VERY IMPORTANT.

By signing below, I agree that I am aware that if I have Medicare as my primary coverage and no secondary coverage, Medicare will pay 80% of my bill and I will pay the remaining 20%.

I am also aware that I might have a deductible which means I might be responsible for some or most of the cost of the services provided to me, depending on my insurance carrier agreement.

DSS Urology might charge me a fee of $50.00 for appointments cancelled or rescheduled two times consecutively. Cancellation or rescheduling of appointments has to be done by 12:00 noon, at least one business day prior to my appointment (Note: Cancelations need to be made monday through friday).

As part of this patient registration process, I am aware that DSS Urology will take a picture of me for the purpose of protecting my health information. A picture could be requested later, when considered necessary by DSS Urology to keep my records updated.

PATIENT SIGNATURE: _____ TODAY'S DATE:_____/_____/_____