West Coast | Urology

PALETZ AGATSTEIN UROLOGY MEDICAL GROUP, INC

PATIENT REGISTRATION

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)			SOCIAL SECURITY #
STREET ADDRESS		CITY, STATE	ZIP CODE
HOME # ( )	CELL # ( )		WORK # ( )
SEX	AGE	DATE OF BIRTH (MM/DD/YYYY)	DRIVER'S LICENSE #
SPOUSE/PARTNER		MARITAL STATUS ☐ Married ☐ Single ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced	

MINOR PATIENT

GUARDIAN'S FULL NAME		RELATIONSHIP	TEL # ( )
STREET ADDRESS		CITY, STATE	ZIP CODE

PRIMARY PHYSICIAN

FULL NAME		OFFICE # ( )	FAX # ( )
STREET ADDRESS		CITY, STATE	ZIP CODE

EMERGENCY NOTIFICATION

NAME		RELATIONSHIP	TEL # ( )
STREET ADDRESS		CITY, STATE	ZIP CODE

EMPLOYMENT

EMPLOYER		OCCUPATION	
STREET ADDRESS		CITY, STATE	ZIP CODE

PRIMARY INSURANCE

INSURANCE NAME		SUBSCRIBER'S NAME (IF NOT PATIENT)	
INSURANCE ADDRESS		RELATIONSHIP	
MEMBER ID/MEDICARE #	GROUP #	SOCIAL SECURITY #	DATE OF BIRTH

SECONDARY INSURANCE

INSURANCE NAME		SUBSCRIBER'S NAME (IF NOT PATIENT)	
INSURANCE CO ADDRESS		RELATIONSHIP	
MEMBER ID #	GROUP #	SOCIAL SECURITY #	DATE OF BIRTH

ADDITIONAL INSURANCE INFORMATION _____

AUTHORIZATION TO PAY

I, _____ HEREBY AUTHORIZE _____ TO PAY DIRECTLY TO PALETZ AGATSTEIN UROLOGY MEDICAL GROUP, INC. THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO THEIR SERVICES AS DESCRIBED ON MY INSURANCE FROM HEREIN, BUT NOT TO EXCEED THE CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID BY MY INSURANCE COMPANY.

SIGNATURE	TODAY'S DATE
X	

☐ Inglewood ☐ Downey ☐ Los Alamitos ACCOUNT NO. _____