LANSING INSTITUTE OF UROLOGY, P.C.

PATIENT REGISTRATION

DATE: ___/___/____

PLEASE READ CAREFULLY AND PRINT YOUR ANSWERS NEATLY.

THIS SHEET BECOMES A PART OF YOUR PERMANENT FILE.

PATIENT INFORMATION:

AGE _____ DOB _____/_____ SEX ☐ M ☐ F

MARITAL STATUS
☐ SINGLE ☐ MARRIED
☐ SEPARATED ☐ DIVORCED

LEGAL NAME: _____/_____/____/
LAST NAME FIRST NAME MIDDLE

HOME ADDRESS: _____/_____/_____/_____
NUMBER & STREET APT. NO. CITY ST ZIP

HOME PHONE: _____/_____

RACE: _____ COUNTY PATIENT RESIDES IN: _____

SOCIAL SECURITY NO: _____-_____-_____ MICH. DRIVER'S LIC. NO: _____

CELL PHONE: _____/_____

EMPLOYER: _____ WORK PHONE: _____/_____

HAVE YOU BEEN SEEN BY US BEFORE AT OUR OFFICE OR HOSPITAL? ☐ YES ☐ NO

REFERRING PHYSICIAN: _____
_

FAMILY PHYSICIAN (PRIMARY CARE): _____

PERSON RESPONSIBLE FOR PAYMENT OF FEES NOT COVERED BY INSURANCE OR FOR A MINOR CHILD:

LEGAL NAME: _____/_____/____/
LAST NAME FIRST NAME MIDDLE

HOME ADDRESS: _____/_____/_____/_____
NUMBER & STREET APT. NO. CITY ST ZIP

HOME PHONE: _____/_____

RACE: _____ COUNTY PATIENT RESIDES IN: _____

SOCIAL SECURITY NO: _____-_____-_____ MICH. DRIVER'S LIC. NO: _____

CELL PHONE: _____/_____

EMPLOYER: _____ WORK PHONE: _____/_____
FULL NAME OF EMPLOYER

EMERGENCY (OTHER THAN SOMEONE LIVING WITH YOU) PHONE NUMBER RELATIONSHIP TO YOU:

CONTACT NAME: _____ ____ / _____ / _____ _____

INSURANCE INSURANCE INFORMATION (WE WILL NEED TO SEE ALL YOUR INSURANCE CARDS TODAY)
WE WILL COLLECT ALL APPLICABLE COPAYS AND FEES FOR OFFICE VISITS AND LAB WORK OF INSURANCE PLANS WE DO NOT PARTICIPATE WITH AT THE TIME OF VISIT:

PRIMARY SUBSCRIBERS
INS. CO. NAME: _____ NAME: _____

D.O.B._____/_____/_____

INS. CO. ADDRESS: _____

RELATIONSHIP TO SUBSCRIBER: _____

POLICY NUMBER: _____ _____
CONTRACT # GROUP #

SECONDARY SUBSCRIBERS
NS. CO. NAME: _____ NAME: _____

D.O.B._____/_____/_____

INS. CO. ADDRESS: _____

RELATIONSHIP TO SUBSCRIBER: _____

POLICY NUMBER: _____ _____
CONTRACT # GROUP #

BLUE CROSS/BLUE SHIELD CERTIFICATION
I UNDERSTAND THAT THIS PROVIDER'S CHARGE MAY EXCEED MY INSURANCE PAYMENT, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT.

SIGNED: X_____

MEDICARE RECIPIENT CERTIFICATION
I, _____, AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM, AND REQUEST PAYMENT OF BENEFITS TO PARTY WHO ACCEPTS ASSIGNMENT.
SIGNED: X _____

DATE SIGNED: X _____/_____/__

OTHER INSURANCE CERTIFICATION

I, _____, AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM. I UNDERSTAND THAT THIS PROVIDER'S CHARGE MAY BE EXCEED MY INSURANCE PAYMENT, AND IF GREATER THAN SUCH PAYMENT I WILL BE RESPONSIBLE FOR THAT AMOUNT.

SIGNED (BY INSURED OR AUTHORIZED PERSON) X _____

DATE SIGNED: _____/_____/_____

Reset Form **Print Form**