NEW JERSEY UROLOGY
Excellence In Care

# Patient Registration Form

**Last Name**: _____ **First Name:** _____ **Middle Name:** _____

**Date of Birth**: _____ **Gender:** ❒Male ❒Female ❒Other

**Race:** ❒African American/Black ❒American Indian/Alaskan Native ❒Asian ❒Caucasian/White
❒Native Hawaiian/Pacific Islander ❒Other _____ ❒Declined

**Ethnicity:** ❒Hispanic or Latino ❒Non-Hispanic or Latino ❒Unknown ❒Declined

**Primary Language:** _____ **Marital Status:** ❒Single ❒Married ❒Widowed ❒Separated

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**Street Address**: _____

**City:** _____ **State:** _____ **ZIP:** _____ **County:** _____

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

**Email:** _____ **Preferred Communication:**_____

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**Emergency Contact:** _____

**Relationship:** _____ **Phone:** _____

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**Referring Physician:** _____ **Phone:** _____

**Address:** _____ **Fax #:** _____

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**Primary Care Physician:** _____ **Phone:** _____

**Address:** _____ **Fax #:** _____

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**Pharmacy Name**: _____ **Phone #:** _____

**Address**: _____ **Fax #:** _____

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**Is patient at a Skilled Nursing Facility?** NO YES _____
Name of Skilled Nursing Facility

## INSURANCE INFORMATION

**Primary Insurance Company:** _____

**Policy #:** _____ **Group #:** _____

**Subscriber / Insured's Name:** _____ **Date of Birth:**_____

**Subscribers SSN #:** _____ **Relationship to Insured:** _____

**Does your insurance require a referral?** ❒Yes ❒No

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**Secondary Insurance Company:** _____

**Policy #:** _____ **Group #:** _____

**Subscriber / Insured's Name:** _____ **Date of Birth:**_____

**Subscribers SSN #:** _____ **Relationship to Insured:** _____

**Does your insurance require a referral?** ❒Yes ❒No

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## WORKERS COMPENSATION INFORMATION (If applicable)

**Workers' Compensation Insurance:** _____

**Employer's Name** _____ **Address:** _____ _____

**Adjuster's Name:** _____

**Claim #:** _____ **Phone #:** _____

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## NO FAULT INFORMATION (If applicable)

**No Fault Insurance:** _____

**Claim #:** _____ **Phone #:** _____

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize New Jersey Urology or my insurance company to release any information required to process my claims. I understand that I am financially responsible for any amount not covered by insurance. I have been informed that copays, deductibles, and any outstanding balances are expected at the time of visit.

_____ _____

**Patient Signature** **Date**

_____ _____

**Authorized Representative Signature** **Date**