

# LANSING INSTITUTE OF UROLOGY, P.C.

## PATIENT REGISTRATION

PLEASE READ CAREFULLY AND PRINT YOUR ANSWERS NEATLY  
THIS SHEET BECOMES A PART OF YOUR PERMANENT FILE.

DATE: \_\_\_\_\_

PATIENT INFORMATION:			AGE _____	BIRTH DATE _____	SEX FEMALE MALE	MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED SEPARATED
LEGAL NAME:	LAST NAME	FIRST NAME	MIDDLE INITIAL			
HOME ADDRESS:				HOME PHONE: _____		
NUMBER & STREET		APT. No.	CITY	STATE	ZIP	
SOCIAL SECURITY NO.			MICH. DRIVER'S LICENSE NO.	CELL PHONE: _____		
EMPLOYER:				WORK PHONE: _____		
HAVE YOU BEEN SEEN BY US BEFORE AT OUR OFFICE OR HOSPITAL?		YES NO	REFERRING PHYSICIAN: FAMILY PHYSICIAN:			

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

LEGAL NAME:	LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO PATIENT	HOME PHONE: _____
HOME ADDRESS:				WORK PHONE: _____	
NUMBER & STREET		Apt. No.	CITY	State	Zip
SOCIAL SECURITY NO. _____		MICHIGAN DRIVER'S LICENSE NO. _____			
EMPLOYER AND FULL ADDRESS: _____					

<b>EMERGENCY (OTHER THAN SOMEONE LIVING WITH YOU)</b>	<b>PHONE NUMBER:</b> _____	<b>RELATIONSHIP TO YOU</b>
<b>CONTACT NAME:</b> _____	_____	_____
<b>ADDRESS:</b> _____		

**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.

<b>PRIMARY</b>	SUBSCRIBER'S
INS. CO. NAME: _____	NAME: _____
INS. CO. ADDRESS: _____	PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____
POLICY NUMBER: _____	Group No. Contract No. Coverage Code

<b>SECONDARY</b>	SUBSCRIBER'S
INS. CO. NAME: _____	NAME: _____
INS. CO. ADDRESS: _____	PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____
POLICY NUMBER: _____	Group No. Contract No. Coverage Code

<b>BLUE CROSS/BLUE SHIELD CERTIFICATION</b> 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 <b>X</b> _____ DATE SIGNED: _____	<b>MEDICARE RECIPIENT CERTIFICATION</b> 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 <b>X</b> _____ DATE SIGNED: _____
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<b>OTHER INSURANCE CERTIFICATION</b> I, _____, AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM. 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 (BY INSURED OR AUTHORIZED PERSON) <b>X</b> _____ DATE SIGNED _____
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