ADVANCED UROLOGY
CENTERS OF NEW YORK
A Division of Integrated Medical Professionals, PLLC

Appt Date _____
Date of Birth _____

Patient Registration

Patient Information

Last Name First Name MI Email address

Address City State Zip Code

Home Phone ( ) _____ - _____ Work Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____ SS # _____ - ___ - _____

Gender M ___ F_____ Marital Status: Married ___ Single___ Divorced ___ Widowed ___

Employer's Name _____ Employer's Address _____

Emergency Contact _____ Relationship _____ Home Phone ( ) ____ - _____ Work Phone ( ) ____ - _____ Cell Phone ( ) ____ - _____

How do you learn about us? Internet Friend Family Physician Provider Directory Other_____

Whom may we thank for referring you? _____

Race

American Indian or Alaska Native Asian Black or African American Native Hawaiian White
Refused to Report / Unreported Other Pacific Islander More than one race

Ethnicity:

Hispanic or Latino Not Hispanic or Latino Refused to Report

Preferred Language

English Spanish Italian Russian Chinese Korean Japanese Other _____

Are you a resident of a: Nursing facility Rehabilitation facility Hospice Admission Date: ____/____/_____

If so, name of facility _____ Phone: ( ) _____ - _____

Address _____

Referring Physician (s) Information

Usual Provider _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Referring Physician _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Primary Care Physician _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Patient Name _____ Date of Birth _____

Primary Insurance Information

Medicare Medicaid Health Insurance Self Pay Worker's Comp No Fault

Policyholder's Name _____ Insurance Name _____

Policyholder's SSN # _____ Claims Address _____

Policyholder's Date of Birth _____ City, State, Zip _____

Relationship to Patient _____ ID # _____ Group # _____

Secondary Insurance Information

Medicare Medicaid Health Insurance Self Pay Worker's Comp No Fault

Policyholder's Name _____ Insurance Name _____

Policyholder's SSN # _____ Claims Address _____

Policyholder's Date of Birth _____ City, State, Zip _____

Relationship to Patient _____ ID # _____ Group # _____

Third Insurance Information

Medicare Medicaid Health Insurance Self Pay Worker's Comp No Fault

Policyholder's Name _____ Insurance Name _____

Policyholder's SSN # _____ Claims Address _____

Policyholder's Date of Birth _____ City, State, Zip _____

Relationship to Patient _____ ID # _____ Group # _____

Guarantor Information

Last Name First Name MI Date of Birth Gender

Address City State Zip Code Email address

Home Phone Work Phone Cell Phone Social Security #

Employer's Name Employer's Address

Relationship to Patient _____

Acknowledgement of Financial Responsibility

I hereby authorize Advanced Urology Centers of New York, a division of Integrated Medical Professionals, to release to all insurance companies / carriers above any medical or other information required for processing insurance claims. I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to Advanced Urology Centers of New York, a division of Integrated Medical Professionals, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient or Authorized Signature (if over 18 years of age) | Printed name of Patient or Authorized Signature (if patient is under 18 years of age) | Date

Pharmacy Information

Pharmacy Name _____ Phone _____ Fax _____

Address _____ City, State, Zip _____