DATE_____

ARIZONA INSTITUTE OF UROLOGY
PATIENT REGISTRATION

OFFICE USE ONLY

ACCOUNT NUMBER _____
Reg By:_____ Date_____

PATIENT INFORMATION

FIRST NAME_____M. I._____ LAST NAME_____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP_____ SOCIAL SECURITY _____

MALE FEMALE (circle) DATE OF BIRTH_____

MARITAL STATUS: (circle) SINGLE MARRIED WIDOWED DIVORCED

EMPLOYMENT STATUS: (circle) EMPLOYED RETIRED FULL-TIME STUDENT OTHER_____

PREFERRED PHARMACY _____

REFERRING PHYSICIAN OR PCP_____

EMAIL ADDRESS_____
HOME PHONE (_____) _____
CELL PHONE (_____) _____
WORK PHONE (_____) _____
EMPLOYER _____
EMPLOYER ADDRESS_____
_____
PHARMACY ADDRESS _____
HOW DID YOU HEAR ABOUT US?_____

EMERGENCY CONTACT (Who does not live with you)

FIRST NAME_____ _____M. I._____

LAST NAME_____

RELATIONSHIP_____
Is contact Parent/Guardian YES NO
HOME PHONE (_____) _____
CELL PHONE (_____) _____
WORK PHONE (_____) _____

INSURANCE INFORMATION PRIMARY

Insurance Name_____ Claims Address_____

City_____ State_____ Zip_____ Phone_____

Policy Number_____ Group Number_____

Subscriber Name (Policy Holder)_____ Relationship_____

Subscriber Address_____

Subscriber Date of Birth_____ Subscriber SSN_____ Subscriber Sex_____

Subscriber Employer_____ Address_____

City_____ State_____ Zip_____ Phone_____

INSURANCE INFORMATION SECONDARY

Insurance Name_____ Claims Address_____

City_____ State_____ Zip_____ Phone_____

Policy Number_____ Group Number_____

Subscriber Name (Policy Holder)_____ Relationship_____

Subscriber Address_____

Subscriber Date of Birth_____ Subscriber SSN_____ Subscriber Sex_____

Subscriber Employer_____ Address_____

City_____ State_____ Zip_____ Phone_____