IMS
UROLOGY

PATIENT REGISTRATION FORM

Patient: _____ Date of Birth: _____ **Account:** _____ Sex: _____

Patient SSN: _____ Email: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Marital Status: ☐Married ☐Single ☐Divorced Employment: ☐Full Time ☐Not Employed ☐Retired

Preferred Language: ☐English ☐Spanish Other: _____

Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino ☐Unknown ☐Declined

Race: ☐White ☐Asian ☐American Indian/Native American ☐Black/African American ☐Native Hawaiian or other Pacific Islander ☐Declined ☐Unknown

Primary Care Provider: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance: **Copayment**: _____	**Secondary Insurance:**
Name: _____	Name:
Address: _____	Address:
Subscriber ID: _____	Subscriber ID:
Group: _____	Group:
Policy Holder Name: _____	Policy Holder Birthday: _____
Relationship to Patient: _____	Phone: _____

AUTHORIZATION TO BILL/PAY: I hereby authorize IMS to release any information required in the course of my examination or treatment to my insurance(s). I also hereby authorize payment directly to IMS for the surgical and/or medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) for today's visit, and all future visits with IMS, and will pay all fees involved should my account(s) be placed with a collection service. Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.

SIGNED: _____ DATE: _____