

**BELLEVUE UROLOGY ASSOCIATES**  
REGISTRATION AND AUTHORIZATIONS

**PATIENT INFORMATION**

<b>Patient's Last Name</b>	<b>First</b>	<b>MI</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Marital Status (circle one)</b> <b>Single</b> <b>Married</b>	<b>Gender (circle one)</b> <b>Male</b> <b>Female</b>
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<b>Birthdate</b>	<b>Age</b>	<b>Social Security Number</b>	<b>Patient Home Phone</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Name of patient's spouse:</b>	<b>Patient Work Phone</b>	<b>Patient Cell Phone</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Email address:**       **Messages may be left:**     on home voice mail     email  
 work phone     do not leave messages

<b>Patient's Employer</b>	<b>Patient's Occupation</b>
<input type="text"/>	<input type="text"/>

<b>Name of local friend/relative – [in case of emergency]</b>	<b>Relationship to patient</b>	<b>Their phone number</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Physician who referred you to this office:</b>	<b>Your primary care physician:</b>
<input type="text"/>	<input type="text"/>

**INSURANCE INFORMATION**    [Please present your insurance cards to the receptionist.]  
**Are you covered by insurance?** \_\_\_yes\_\_\_no    **If yes, please complete insurance information below:**  
**Patient's relationship to insurance subscriber:** \_\_\_ Self \_\_\_ Spouse \_\_\_ Child  
**Does the patient have secondary insurance?** \_\_\_yes\_\_\_no    **If yes, insurance name:** \_\_\_\_\_

**FINANCIAL / RELEASE OF INFORMATION AUTHORIZATION**  
I request that payment of authorized insurance benefits be made on my behalf to Bellevue Urology Associates for all services rendered to me by Bellevue Urology Associates. I understand I am responsible for and will pay all charges not paid by my insurance.  
I authorize the release of my medical information to insurance company(s) and/or other users as authorized or required by law. My permission and commitment is valid until I rescind it in writing.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of responsible person if patient unable to sign**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Position / Title of responsible person**