NORTH IDAHO urology

Patient Registration Form

Referred By: _____Primary Care Physician: _____

Patient Name: _____Male_____Female_____

Address: _____City:_____State:_____Zip:_____

Phone Number :(___) _____Cell :(___) _____Work :(___) _____

Social Security #:_____ Date of Birth: _____Age:_____

Race:_____ Occupation: _____ Employer: _____

Spouse's Name: _____ Birth Date of Spouse: _____

Emergency Contact: _____Phone Number: (___) _____Relationship:_____

EMAIL: _____ PREFERRED PHARMACY: _____

Responsible Party (If other than patient)
Name of person responsible for this account: _____ Relationship: _____

Address: _____ Home Phone: (____) _____Work:_____

Occupation: _____ Employer: _____Date of Birth: _____

Do you have insurance? Yes_____ No_____ **If no, Self pay ($200 minimum due at each appointment)**

Do we have permission to?

Leave a message on your answering machine at home?	Yes _____	No _____
Leave a message at your place of employment?	Yes _____	No _____
Discuss your medical condition with any member of your household?	Yes _____	No _____

If yes, who may we speak to? _____ Relationship: _____

I have been given the opportunity to obtain a copy of the HIPAA Privacy Rules and the Patient Rights and Responsibilities from this provider (available online at www.niurology.com and at North Idaho Urology). I hereby authorize North Idaho Urology to apply for benefits for services rendered.

Signature: _____ Date: _____