NORTH IDAHO urology

Patient Registration Form

Referring Physician: _____Primary Care Physician: _____

Patient Name: _____Male_____ Female_____

Address: _____City: _____State: _____Zip: _____

Home Phone :(___) _____ Cell :(____) _____ Work : (___) _____

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

Email: _____ **PREFERRED PHARMACY:** _____

Occupation: _____ Employer: _____

Preferred Language _____ Race: _____

Please list below your emergency and HIPAA contacts. We can only speak to HIPAA contacts regarding your personal information including scheduling appointments and medical information.

Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay
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Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay

Responsible Party (If other than patient)

Name of person responsible for this account: _____ Relationship: _____

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

Occupation: _____ Employer: _____Date of Birth: _____

Do you have insurance? Yes: _____ No: _____ **If no, Self pay ($343 new patient or $271 per follow up)**

Primary Insurance Plan Name: _____

Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

Secondary Insurance Plan Name: _____

Subscriber Name: _____ **DOB:** _____ **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: _____