



Patient Registration Form

Referring Physician: _____ Primary Care Physician: _____

Patient Name: _____ Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone : (____) _____ Cell : (____) _____ Okay to leave a detailed message: Y ☐ N ☐

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

Email: _____ PREFERRED PHARMACY: _____

Spouse's Name: _____ Spouse's DOB: _____ ☐ HIPAA okay

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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Do you have insurance? Yes: _____ No: _____ **If no, Self pay (\$383 new patient or \$293 per follow up)**

Primary Insurance Plan Name: _____

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

Secondary Insurance Plan Name: _____

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

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