NORTH IDAHO urology

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: _____

Spouse's Phone Number: _____ ☐ **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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Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay

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: _____