Southern Urogynecology
Center for Incontinence and Female Pelvic Medicine

NEW PATIENT REGISTRATION

PRIMARY MD:_____ ***OB/GYN:***_____ ***PHARMACY:***_____

Section I: Patient Information Date_____

Name:_____ _____ _____ _____ _____
Last First MI Prefix Suffix Maiden Name Nickname (prefer to be called)

Address:_____ _____ _____ _____
Street Suite/Apt City State Zip

DOB:_____ Gender: _____ Social Security #:_____ Email:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Phone (_____)_____ Employer:_____ Pref Language _____

Rel to Primary Insured;_____ Rel to Secondary Insured:_____

Work Phone (____) _____ Ethnicity: Caucasian / African American / Hispanic/ Asian / Other

REMINDERS:

Cell Phone (_____)_____ Preferred Follow Up Method: _____Email _____TextMsg _____Voice Msg
(check all that apply or are acceptable)

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____Employer_____ Work Phone_____

Whom may we thank for referring you? _____

If self referred how did you hear about us?_____

Person to contact in case of emergency_____ Relationship:_____ Phone_____

Section II Responsible Party/Guarantor

(Complete if someone other than yourself is legally responsible for you or your bills.)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

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

Phone: (___)_____ Employer_____ Work Phone (___)_____ SSN#_____

Section III Insurance Information

Primary Carrier:_____ Policy#_____ Group#_____

Name of Insured_____ _____ _____
Last First MI Prefix Suffixx

Address:_____ City:_____State:_____Zip_____
Street Suite/Apt #

DOB_____ Social Security #:_____ Gender:_____ Relationship to Patient _____

Employer:_____ Address of Employer:_____City_____State:_____Zip _____

Secondary Carrier:_____ Policy#_____ Group#_____

Name of Insured_____ _____ _____
Last First MI Prefix Suffixx

Address:_____ City:_____State:_____Zip_____
Street Suite/Apt #

DOB_____ Social Security #:_____ Gender:_____ Relationship to Patient _____

Employer:_____ Address of Employer:_____City_____State:_____Zip _____

I understand that payment is due at time service is rendered. I hereby authorize the release of any medical information to my insurance company and any physicians involved in my care. I realize this authorization allows Southern Urogynecology to release my medical records as stated above. I hereby assign all MEDICAL and/or SURGICAL benefits that are paid by any insurance carrier on my behalf, or that I am entitled to have paid, to Southern Urogynecology. I understand that Southern Urogynecology does not extend credit. I acknowledge and understand that insurance is filed as a courtesy and any contract with regard to insurance is between me and the carrier. I understand that in the event my account is turned over for collection, I may incur and am responsible for any additional fees or costs associated with collection of my account.

SIGNED:_____ DATE:_____