The Kidney Stone Center
REGISTRATION FORM

Today's Date:	Referring Urologist:

PATIENT INFORMATION

Patient Name: Last: First:	MI:	Email:
Address: [Address/ P.O Box, City, State, ZIP Code]		

Social Security #:	Sex:	Date of Birth:	Home phone:	Cell phone:
Marital Status:	Height:	Weight:	Occupation:	Employer:

INSURANCE INFORMATION

(Please bring a copy of your insurance cards)

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone:
Primary insurance:		Policy #:	

Subscriber's name:	Subscriber's SSN:	Date of Birth:	Group #	Co-Payment:
Patient's relationship to subscriber:				

Secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:
Patient's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone:	Work phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Kidney Stone Center or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date