

VASECTOMY CENTER PLLC

REGISTRATION FORM

(Please Print)

Today's date:		PCP:				
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date: / /		Age:	Sex: Male
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:		City:		State:		ZIP Code:
Occupation:		Employer:			Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill (if different):		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance: _____						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY				
Name of local friend or relative:		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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 Vasectomy Center PLLC or insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	