



## PATIENT REGISTRATION FORM

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
(Last, First, Middle Initial)

Address: \_\_\_\_\_  
(City, Street, State, Zip)

Home Phone Number (\_\_\_\_) \_\_\_\_\_ Marital Status  Single  Divorced  
 Married  Widowed Occupation \_\_\_\_\_

Employer Name and Phone Number \_\_\_\_\_ (\_\_\_\_)

Emergency Contact Name and Phone Number \_\_\_\_\_ (\_\_\_\_)

Referred By \_\_\_\_\_ Primary Care Physician & Phone Number \_\_\_\_\_

Primary Insurance Plan Name & Claims Address \_\_\_\_\_  
(Located on back of card)

Insurance Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Holder/Subscriber \_\_\_\_\_ Relationship  Self  Child  
 Spouse  Other

Secondary Insurance Plan Name & Claims Address \_\_\_\_\_  
(Located on back of card)

Insurance Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Holder/Subscriber \_\_\_\_\_ Relationship  Self  Child  
 Spouse  Other

Person Financially Responsible for Services/Relationship to Patient \_\_\_\_\_

What lab does your insurance prefer? <input type="checkbox"/> LabCorp <input type="checkbox"/> Smith Kline <input type="checkbox"/> Candler <input type="checkbox"/> Quest <input type="checkbox"/> Memorial <input type="checkbox"/> LabOne	What hospital does your insurance prefer? <input type="checkbox"/> Memorial Health University Medical Center <input type="checkbox"/> St. Joseph's/Candler	What is your preferred pharmacy/location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this visit require a referral/authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Referrals:** It is your responsibility to understand your insurance plans and know which services require a referral. If we do not have a referral you may be given the option of rescheduling or assuming financial responsibility for the visit by signing a waiver.  
**Contracted facilities:** Your insurance contract may require that you participate with specific physicians, hospitals, and labs. It is your responsibility to understand these requirements and advise our staff of such provisions. Our office cannot be responsible for rejected claims as a result of the use of non-contracted labs and hospitals.  
**Co-Payments:** Co-payments are due prior to services rendered.  
**Medicare:** DOES NOT COVER ROUTINE SERVICES. Payment is expected at the time of service.

Please sign below indicating:

- I have read the above and fully understand my insurance responsibilities.
- I consent to Urogynecology Center of Savannah to render medical care deemed necessary by Joseph T. Stubbs III, MD.
- I authorize Urogynecology Center of Savannah and its agents to bill my insurance company for services rendered.
- I authorize Urogynecology Center of Savannah and its agents to release any medical information required by my insurance to determine benefits payable
- I authorize that payment be made directly to Urogynecology Center of Savannah.

Signature Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_