



S A V A N N A H

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PATIENT REGISTRATION FORM

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

Address: (City, Street, State, Zip) Single Divorced

Home Phone Number ( ) Marital Status 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 Self Child

Policy Holder/Subscriber Relationship Spouse Other

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

Insurance Policy Number Group Number Self Child

Policy Holder/Subscriber Relationship Spouse Other

Person Financially Responsible for Services/Relationship to Patient

What lab does your insurance prefer? What hospital does your insurance prefer? What is your preferred pharmacy/location? Does this visit require a referral/authorization?

Referrals: It is your responsibility to understand your insurance plans and know which services require a referral. Contracted facilities: Your insurance contract may require that you participate with specific physicians, hospitals, and labs. Medicare: DOES NOT COVER ROUTINE SERVICES.

Please sign below indicating: I have read the above and fully understand my insurance responsibilities. I consent to Urogyn to render medical care deemed necessary by Joseph T. Stubbs III, MD. I authorize Urogyn and its agents to bill my insurance company for services rendered. I authorize Urogyn and its agents to release any medical information required by my insurance to determine benefits payable. I authorize that payment be made directly to Urogyn. Signature Patient/Guardian Date