THE BHALANI UROLOGY INSTITUTE

PATIENT REGISTRATION FORM

Full Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

* Preferred Phone Number: ☐ Home ☐ Cell _____

* Email Address: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Other: _____ ☐ Unknown/Declined

Preferred Language: ☐ English ☐ Spanish ☐ Chinese (Cantonese) ☐ Chinese (Mandarin) ☐ French
☐ German ☐ Italian ☐ Korean ☐ Gujarati ☐ Other: _____

Employer: _____ Employer Phone: _____

For your convenience, we send Appointment Reminders:
☐ Check here if you prefer to opt out

Please refer to our financial policy regarding cancellations/no-shows.

Pharmacy Information

Pharmacy Name: _____ Phone: _____ Fax: _____
Pharmacy Address: _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name: _____ Date of Birth: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
* Preferred Phone Number: ☐ Home ☐ Cell _____

*By providing a phone number or email address, you understand that communication by email and text may be an unsecure form of communication and you expressly consent and authorize The Bhalani Urology Institute to contact you via phone calls (through the use of any dialing equipment such as artificial or pre-recorded voice technology and/or automated telephone dialing systems), texts, and/or emails, including for appointment reminders, payment-related messages, quality improvement communications such as surveys, and invitations to join our secure patient portal, if available.

Emergency Contacts Information and Relationship to Patient

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Referring Physician Information

Physician Name: _____ Specialty: _____ Office Name: _____
Address: _____ Phone: _____ Fax: _____

Primary Care Physician Information (if different than referring physician):

Physician Name: _____ Specialty: _____ Office Name: _____
Address: _____ Phone: _____ Fax: _____
Does your insurance require a referral? ☐ Yes ☐ No; **if yes**, please provide the referral to the receptionist

	Primary Insurance	Secondary Insurance
Name of Insurance		
Policy Holder Name and Date of Birth		
Policy Holder Relationship to Patient		
Policy/Member ID Number		
Group/Plan Number		

Patient/Guarantor Signature: _____ **Date:** _____