PATIENT REGISTRATION

Please Print Clearly

PATIENT NAME First Middle Last				DATE OF BIRTH	AGE
HOME ADDRESS APT. NO.	CITY		STATE	ZIP CODE	
OCCUPATION EMPLOYED: ☐FT ☐PT RETIRED ☐ STUDENT ☐	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX	HOME PHONE	
EMPLOYER (or previous employer, if retired)	ADDRESS			WORK PHONE	
SPOUSE (OR PARENT) NAME	SPOUSE (OR PARENT) EMPLOYER			SPOUSE (OR PARENT) WORK PHONE	
SPOUSE (OR PARENT) ADDRESS					
NEAREST RELATIVE / FRIEND	RELATIONSHIP	HOME PHONE		WORK PHONE	
RELATIVE / FRIEND ADDRESS					
REFERRING PHYSICIAN	ADDRESS			TELEPHONE	
ANY KNOWN ALLERGIES? ☐NO ☐YES IF YES PLEASE LIST:					
HAVE YOU BEEN TREATED IN THIS OFFICE IN THE PAST? ☐NO ☐YES IF YES, APPROXIMATE DATE:		DOES YOUR INSURANCE REQUIRE A SECOND OPINION FOR SURGERY? ☐NO ☐YES			

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, money order or Visa, MasterCard or American Express.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Visa, MasterCard or American Express.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above. X____________________

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME LAST NAME			RELATIONSHIP TO PATIENT
	HOME ADDRESS		CITY	STATE
	EMPLOYER		WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME DOES YOUR INSURANCE REQUIRE PRE-CERTIFICATION? ☐YES ☐NO		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME IS THIS THROUGH EMPLOYER ☐ OR INDIVIDUAL ☐		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT AUTHORIZATION

I,______________________________, hereby authorize ARNOLD M. KWART M.D./ WASHINGTON HOSPITAL CENTER, to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, and / or ______________________________ Insurance Company, be made directly to the above-named provider.
(Name of Other Ins. Co.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including, medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

______________________ ______________________________________

Date *Signature of Subscriber or Beneficiary*

ACCOUNT NUMBER

PLEASE COMPLETE INFORMATION REQUESTED ON THE REVERSE SIDE

NAME: ______________________ DATE: ______________________

Please complete the following form. It will allow us to expedite your visit and spend more time on your Urologic problem.

Any current illness:

Prior Urologic or Major Surgery:

Present Medications:

Allergies to Medications:

Do you require antibiotic prophylaxis prior to procedures?

Significant Family Illness:

Social History: Marital Status: S M D W Do you Smoke: __________
Do you drink Alcohol: ________ Number of drinks per day: ________

Do you now or have you had any problems related to the following systems? Circle YES or NO.
Please explain any YES answers in the space below.

Constitutional Symptoms:

Weight loss	Y	N
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other ______		

Genitourinary:

Urinary retention	Y	N
Kidney Stones	Y	N
Impotence	Y	N
Urinary Infection	Y	N
Other ______		

Integumentary:

Skin rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other ______		

Eyes:

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other ______		

Neurological:

Tremors	Y	N
Dizzy Spells	Y	N
Numbness / tingling	Y	N
Other ______		

Endocrine:

Excessive Thirst	Y	N
Too hot / cold	Y	N
Tired / Sluggish	Y	N
Other ______		

Gastrointestinal:

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other ______		

Cardiovascular:

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other ______		

Musculoskeletal:

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other ______		

Ear/Nose/Throat:

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N
Other ______		

Respiratory:

Wheezing	Y	N
Cough	Y	N
Shortness of Breath	Y	N
Other ______		

Allergic/Immunologic:

Hay Fever	Y	N
Food Allergies	Y	N
Other ______		

Hematologic/Lymphatic:

Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Other ______		