



# NORTHGATE UROLOGY ASSOCIATES

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## REGISTRATION FORM

*Please Print*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Family Physician \_\_\_\_\_ Address \_\_\_\_\_

Referred By \_\_\_\_\_

Occupation \_\_\_\_\_

Employed By \_\_\_\_\_ Work Phone \_\_\_\_\_

## INSURANCE INFORMATION

### PRIMARY INSURANCE:

### SECONDARY INSURANCE:

Name of Insurance Carrier \_\_\_\_\_ Name of Insurance Carrier \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

I.D. # \_\_\_\_\_ DOB \_\_\_\_\_ I.D. # \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

*In an effort to provide confidentiality/privacy we ask that you provide the names of any party other than yourself with whom we have permission to share information regarding your health. (Lab Results, Test Results, Medication Refills, etc.)  
\*\* Remember that it is your responsibility to advise us if the names on this list should change\*\**

Name \_\_\_\_\_ Name \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST TO BE COPIED - THANK YOU**

## PAYMENT AGREEMENT

In the event my insurance disallows claim for this exam, I hereby agree to pay Northgate Urology Associates the usual and customary fees for services rendered during my lifetime. I understand that if my account becomes delinquent, I will be responsible for any fees that may not be covered by my insurance company (for whatever reason) that may be required for collection of these services (including making payment arrangements) when necessary. I authorize the release of any medical information necessary to process any medical claims made on my behalf by Northgate Urology Associates. I further authorize payment of medical benefits to Northgate Urology Associates for any medical services rendered to me. I permit a copy of this authorization to be used in place of the original.

## STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its Carriers any information required to process my Medicare claims. I request that payment under the medical insurance programs be made to Northgate Urology Associates for services provided to me during my lifetime.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_