ARIZONA CENTER FOR VASECTOMY AND UROLOGY

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information.

Please Print. **All information is confidential and is released only with your consent.** **Today's Date:**

Last: First: MI:

Sex: Male Female Date of Birth:

Status: Single Married Widowed Divorced

Parent or Legal Guardian if Patient is a Minor:

Patient's Social Security Number

Home Address City State Zip

Mailing Address if Different City State Zip

Please indicate phone number and order of call preference (1st, 2nd, 3rd)

Would you like to Opt into our TXT Appointment reminders? YES NO

( ) Home Ph # : ( ) Work Ph # : ( ) Cell Ph # :

Employer's Name Occupation

Primary Care Physician: | How were you referred to our practice?

Notify in Case of Emergency:

Name Relationship Home Ph # Work Ph #

Address City State Zip

Insurance Information: (All information requested MUST be furnished in order for carrier to be billed)

Primary Insurance Company

Insurance ID No.: Group#:

Subscriber's Name Date of Birth Relation to Patient:

Secondary Insurance Company

Insurance ID No.: Group#:

Subscriber's Name Date of Birth Relation to Patient

Signature _____ Printed Name _____

Email: _____