NEW JERSEY UROLOGY
Excellence In Care

Patient Registration

Last Name: _____ First Name: _____ MI: _____
Sex: ☐ Male ☐ Female Date of Birth: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Mobile Phone: _____
**Please circle preferred phone number*
Email: _____

Guardian (if applicable)
Last Name: _____
First Name: _____
MI: _____

Emergency Contact
Name: _____
Relationship: _____
Primary Phone: _____

Patient's Care Team
Primary Care Physician: _____
Referring Physician: _____

Employment
Employer Name: _____
Employer Phone: _____
Occupation: _____

Pharmacy
Local Pharmacy: _____ Mail Order Pharmacy: _____
Address: _____ Address: _____

Race: _____ Ethnicity: _____
Marital Status: _____
How did you hear about us? _____

Guarantor (to whom statements are sent)
Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Relationship to Patient: _____

Mailing Address ☐ (Check box if same as patient's address)
Address: _____
City: _____ State: _____ Zip: _____

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Preferred Lab: _____
Preferred Imaging Facility: _____
Provider at New Jersey Urology: _____
Primary Language: _____

Health Insurance Coverage

Primary Insurance: _____ Subscriber ID: _____

Group Number: _____ Co-Pay Amount: _____

Secondary Insurance: _____ Subscriber ID: _____

Were you injured in a motor vehicle accident? ☐ Yes ☐ No Were you injured at work? ☐ Yes ☐ No

Insurance Carrier: _____ Claim Number: _____

Date of Injury: _____ Adjuster's Name: _____

Adjuster's Phone Number: _____ Address: _____

Attorney's Name: _____ Phone: _____ Fax: _____

The above information is true to the best of my knowledge; I authorize my insurance benefits be paid directly to the Physician/Practice. I understand that I am financially responsible for any balance. I also authorize New Jersey Urology, LLC (NJU) or my insurance company to release any information required to process my claims.

In accordance with Horizon BCBS Omnia Plan guidelines, we are required to inform you that NJU is a Tier 1 level practice with the Horizon Omnia Plan.

Patient Name: _____ **Patient Signature**: _____
Guardian/Representative: _____

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NJU Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices which provides information about how we may use and disclose Protected Health Information (PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

☐ I acknowledge that I have received a copy of the New Jersey Urology Notice of Privacy Practices.

☐ We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the patient, but it could not be obtained because: _____

_____

Employee Signature/Date: _____ (For Office Use Only)

We cannot discuss your PHI with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below name(s) of the individual(s) (family, friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

	Name	Relationship to Patient	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

_____ _____

Name of Patient (print) Date of Birth

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Representative Date

(Required if patient is a minor or an adult who is unable to sign this form)

_____ _____

Relationship of Patient Representative to Patient Print Name