UROLOGY SAN ANTONIO

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PATIENT REGISTRATION / ENCOUNTER FORM

REV. 8/15/2013

Appointment Date/Time		Medical Provider	
Appointment Reason/Memo		Co-Pay	OFFICE USE

Patient Information

Patient		Address	
Account #	OFFICE USE		
Date of Birth		City	
Age		State	
Gender		Zip	
Doctor		Marital Status	
Social Security #		Home Phone	
Preferred Language		Work Phone	
Race		Cell Phone	
Ethnicity		Email	
Referred By		Highest Education	

Primary Physician

Primary Physician		Address	
Office Phone			
Fax			

Insurance Information (including Medicare and/or Medicaid)

Primary Insurance		Secondary Insurance	
Policy #		Policy #	
Group #		Group #	
Insured's Name		Insured's Name	
Insured's D.O.B		Insured's D.O.B	
Insured's Gender		Insured's Gender	

Pharmacy Information and Emergency Contact Information

Preferred Pharmacy		Emergency Contact	
Address/Intersection		Relationship	
City, State, Zip		Primary Number	
Phone #		Secondary Number	