

**Lakes Area Urology, P.A.**  
**Patient Registration**

**Please print clearly and answer all questions:**

**Today's Date:** \_\_\_\_\_

**Patient Information**

Name: (Last) \_\_\_\_\_ (First): \_\_\_\_\_ (Middle) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

If minor child, parents' name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Billing Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Patient Employment:  Employed  Retired  Unemployed  Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status (check one)  Single  Married  Widowed  Divorced  Separated

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_  
(Required for insurance billing)

Spouse's or (if minor – Parents') Employer: \_\_\_\_\_

Spouse's or (if minor – Parents') Business Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Person to contact in case of emergency (not at same address):  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary Care Physician (Name and Address) \_\_\_\_\_

**Medical Insurance:**

Primary Health Ins: \_\_\_\_\_ Policy Holder Name & Birthdate: \_\_\_\_\_

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

Secondary Health Ins: \_\_\_\_\_ Policy Holder Name & Birthdate: \_\_\_\_\_

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

**PATIENT SIGNATURE:** \_\_\_\_\_