☐ Kenneth C. Hsiao, M.D.
☐ James B. Karol, M.D.
☐ Robert W. Kindrachuk, M.D.

☐ James K. Mooney, M.D.
☐ John W. Roberts, M.D.
☐ Andrew D. Smith, M.D.
☐ C. Charles Wen, M.D.

Registration Record

Last Name: ____________________ MI. ____

First Name: ____________________________

Address: ______________________________

City: ________________________ State: ____

Zip Code: ___________ Male: ___ Female: ___

Employer: ______________________________

Home Phone: (_____) _______________

Cell Phone: (_____) _______________

Date of Birth: _____/_____/_______

SS#: ______ - ______ - ______

Marital Status: _____________________

Email: _____________________________

****

PRIMARY INSURANCE: ____

ID#: ______________________________ GROUP #: ________________

SUBSCRIBER NAME: ______________________________ SUBSCRIBER D.O.B.: ___/___/___

EMPLOYER: _______________________ RELATIONSHIP TO INSURED: __________________

SECONDARY INSURANCE: ____

ID#: ______________________________ GROUP #: ________________

SUBSCRIBER NAME: ______________________________ SUBSCRIBER D.O.B.: ___/___/___

EMPLOYER: _______________________ RELATIONSHIP TO INSURED: __________________

****

Referring Physician: ____
First Name Last Name

Referring Physician Phone: (_____)_________________

Emergency Contact: __________________________________ Phone: (____) _____________

Allergies to Medications: ____

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I understand that my signature authorizes Medicare and/or private insurance carriers to pay NorCal Urology Medical Group, Inc. directly for all services provided by NorCal Urology Medical Group physicians. I understand that my signature authorizes NorCal Urology Medical Group to release my medical records to expedite payment of Medicare benefits and/or private care benefits. I understand that I am responsible for payment of medical services. I understand I am responsible for payment of a $25.00 cancellation fee for failure to provide at least 24 hour notice to cancel an appointment with NorCal Urology Medical Group.

____ _____/_____/______
Beneficiary Signature Date

☐ PT. REG COMPLETED	☐ CO-PAY COLLECTED	☐ INS. CARD COPIED	☐ REFERRAL ATTACHED
OFFICE USE ONLY:	REVIEWED BY: _______________________		DATE: ______________