

ORG# \_\_\_\_\_

MRN# \_\_\_\_\_



<i>Patient</i>	<i>Parent/Responsible Party- if different</i> Patient Relationship <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Legal Last Name	
Legal First Name, Middle	
Nick Name	
SSN	
Date of Birth	
Sex / Marital Status	<input type="checkbox"/> Male <input type="checkbox"/> Female / <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Address	
Apt/Bldg/Suite #	
City, State, Zip	
Home Phone	
Work Phone	
Mobile Phone	
Email Address	
Employer Name	
Address	
City, State, Zip	
Emergency Contact	Reason for visit _____
Name	_____
Home Phone	Who referred you? _____
Work Phone	Permission to leave voice mail @ primary phone number?
Mobile	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Insurance	Secondary Insurance
Insurance Company	
Primary Policyholder Name	
Primary Policyholder DOB	
Primary Policyholder Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female

**Primary Care Physician**

\_\_\_\_\_

If none, do you need help finding a Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Authorization, Assignment of Benefits, and Referral Medical Release**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Request for Treatment:**

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

289545 (12/14)



Carolina HealthCare System

McKay Urology - Lincoln  
Patient Registration

**Patient Information or Sticker**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medical Record #: \_\_\_\_\_