Bedford Regional
UROLOGY
We Get You Going

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: ___-___-___

Date of Birth: ___/___/___ Sex: ☐ M ☐ F (Check One): ☐ Married ☐ Single ☐ Divorced ☐ Widow

Address: _____
(Street) (City/State/Zip)

Home Phone: (___) ___-___ Email Address: _____

Would you be interested in having communications sent to you via your email address?
(Examples: appointment reminders, administrative updates, health bulletins): ☐ Yes ☐ No

Employer Name: _____ Employer Phone Number: (___) ___-___

Employer Address: _____
(Street) (City/State/Zip)

Primary Care Physician: _____ Copay Amount: $ _____

How did you hear about our practice? _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: ___-___-___

Relationship to Patient (please check): ☐ self, ☐ spouse, or ☐ parent Date of Birth: ___/___/___

Address: _____ Phone Number: (___) ___-___

Employer Name: _____ Employer Phone Number: (___) ___-___

Employer Address: _____
(Street) (City/State/Zip)

Who to call for an emergency:

Name: _____ Relationship: _____

Address: _____
(Street) (City/State/Zip)

Home Phone: (___) ___-___ Work Phone: (___) ___-___

Do you grant this person access to your medical records, in the case of an emergency? ☐ Yes ☐ No

Date: _____

First Insurance Information

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: ___-___-___ Policy Holder's Date of Birth: ___/___/___ Sex: ☐ M / ☐ F

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Second Insurance Information

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: ___-___-___ Policy Holder's Date of Birth: ___/___/___ Sex: ☐ M / ☐ F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?
IF YES, PLEASE NOTIFY THE RECEPTIONIST. ☐ Yes ☐ No

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Bedford Regional Urology. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

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202 Memorial Drive #2
Everett, PA 15537
Phone: (814) 623-0552

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2950 Fairway Drive #2
Altoona, PA 16602
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East Freedom Surgical Associates
15721 Dunnings Highway
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