Wayne Memorial Hospital
Honesdale, PA 18431
Urology

PATIENT REGISTRATION

PATIENT IDENTIFICATION

LEGAL NAME _____
(Last Name, First Name)

FIRST NAME USED (Preferred Name): _____ **ALIAS:**_____

LEGAL SEX:_____ **DOB** _____ **SSN #** _____ **MOTHER'S MAIDEN NAME**: _____

PATIENT CONTACT INFORMATION

ADDRESS: _____ **HOME PHONE:** _____
_____ **CELL PHONE:** _____
EMAIL: _____ **WORK PHONE**: _____

DEMOGRAPHICS

PREFERRED LANGUAGE:_____ **RACE:**_____ **ETHNICITY:**_____
□ DECLINE TO ANSWER □ DECLINE TO ANSWER □ DECLINE TO ANSWER

MARITAL STATUS: ☐ Married □Single □ Divorced □ Separated □ Widowed □Unknown

SEXUAL ORIENTATION: ☐ Lesbian, gay or homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Don't know
☐ Other (please describe) _____ ☐ Choose not to disclose

GENDER IDENTITY: ☐ _____ ☐ Choose not to disclose

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____
HOME PHONE: _____ **CELL PHONE:** _____

NEXT OF KIN NAME: _____ **RELATIONSHIP:** _____
HOME PHONE: _____ **CELL PHONE:** _____

GUARDIAN NAME: _____ **RELATIONSHIP:** _____
HOME PHONE: _____ **CELL PHONE:** _____

EMPLOYMENT

EMPLOYER NAME:_____ **OCCUPATION:**_____ **PHONE:**_____

INSURANCE INFORMATION - Patients will be considered a self-pay pay account until information is provided

PRIMARY INSURANCE

INSURANCE ADDRESS: _____
INSURANCE POLICY HOLDER NAME:_____ ☐ PATIENT ☐ OTHER
POLICY HOLDER DOB:_____ RELATIONSHIP TO PATIENT:_____
INSURANCE ID# :_____ GROUP ID#:_____
ADDRESS OF INSURED: _____
TELEPHONE NUMBER OF INSURED: _____ SSN OF INSURED: _____

SECONDARY INSURANCE

INSURANCE ADDRESS: _____
INSURANCE POLICY HOLDER NAME:_____ ☐ PATIENT ☐ OTHER
POLICY HOLDER DOB:_____ RELATIONSHIP TO PATIENT:_____
INSURANCE ID# :_____ GROUP ID#:_____
ADDRESS OF INSURED: _____
TELEPHONE NUMBER OF INSURED: _____ SSN OF INSURED: _____

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Patient Signature: _____ **Date:** _____

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.