West Alabama Urology Associates
Registration Form

Today's Date:	PCP:	Referring Physician:

Patient Information

Patient's Last Name:	First Name:	Middle Name:
Date of Birth:	Social Security Number:	Email Address:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Sex: Male Female	Ethnicity: Hispanic Non-Hispanic	Preferred Language: English Spanish Sign Language Other:
Marital Status: Married Single Divorced Widow	Race: White Hispanic American Indian African American Decline Other	
Emergency Contact:	Relationship to Patient:	Phone Number:

Responsible Party

(If patient is a minor (under the age of 18), the parent or guardian bringing in the patient will be listed as the guarantor.) Leave section blank if the patient is over the age of 18.

Patient's Last Name:	First Name:	Middle Name:
Date of Birth:	Phone #:	Relationship to Patient:
Address of Responsible Party:		
City/State/Zip:	Email Address:	

Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Policy Number:	Policy Number:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Relationship to Patient:	Relationship to Patient:

Request to Communicate: I authorize West Alabama Urology Associates to contact me regarding clinical services by the means provided below. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, lab results, or any other healthcare-related function. I understand that information transmitted via telephone, text message, or e-mail can be intercepted and recorded by unrelated third parties. I authorize my health care provider to utilize this unsecured method of communication for limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual if I am unavailable at the number provided by me for the purposes shown above. I understand it is my responsibility to notify West Alabama Urology Associates should this information change. I understand that I **do not** have to provide any of the communication sources.

Complete and check all that apply:

Home Phone: _____ ☐ You may leave a detailed message

Cell Phone: _____ ☐ You may leave a detailed message or sent text

Work Phone: _____ ☐ You may send a detailed message

Email: _____ ☐ You may send a detailed message

Would you like to enroll in the patient portal? ☐ Yes ☐ No

Do you give us permission to contact or leave a message with someone other than you? ☐ Yes ☐ No

If so, please provide name and phone number of this person: _____

Signature of patient or patient representative: _____