James G. Knight MD
Board Certified Urologist

Patient Registration Information- Please Print

PATIENT INFORMATION

Patient's Name: _____ _____
LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

Date of Birth: _____ _____ Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
MM/DD/YYY AGE

Home Address: _____
STREET City State ZIP CODE

Home Phone: (_____)_____ Occupation: _____ Referred by: _____

Employer: _____ Work Phone: (_____)_____

Work Address: _____
STREET City State ZIP CODE

In case of emergency, please notify: _____ Relationship: _____ Phone (_____)_____

SPOUSE-RESPONSIBLE PARTY

Spouse's Name: _____ _____
LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

Spouse's Employer: _____ Occupation: _____

Work Address: _____ Work Phone: (_____)_____
STREET City State ZIP CODE

Responsible Party: _____ _____
LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

Address: _____ Home Phone: (_____)_____
STREET City State ZIP CODE

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: (_____)_____
STREET City State ZIP CODE

INSURANCE INFORMATION

Medicare #: _____ Medi-Cal #: _____

PRIVATE INSURANCE

(1) Company: _____ Certificate #: _____

Street Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ Insured's Name: _____

(1) Company: _____ Certificate #: _____

Street Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ Insured's Name: _____

Other

If work related Injury:

Date of Injury: _____ Date last worked: _____ Claim #: _____

Employer Insurance Company: _____ Phone: (_____)_____

Address: _____
STREET City State ZIP CODE

Ins. Adjuster, Attorney, Etc.: _____ Phone: (_____)_____

AUTHORIZATION:

I hereby consent to any necessary medical treatment/ physical examination required by myself or the minor named above for whom I am legally responsible

ASSIGNMENT:

I permit to doctor's office any benefits due for their services rendered.
I understand that I am financially responsible for all charges, whether or not covered by my insurance company or any other insurance company.

MEDICAL RECORDS:

Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original.
Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We can not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature: _____ Date: _____