ADVANCED UROLOGY
KINGSTON

Medical Offices of Dr. Reaud Gafoor, B.Sc. (Biology), M.B.B.S., D.M. (Urology.)

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Patient Registration Form

Patient Information

Patient Name (Last, First, Middle)_____ Birthday (MM/DD/YYYY) _____Sex (M/F) __
Marital Status (Married / Single / Divorced / other) _____ Email:_____
Home Phone: _____ Mobile Phone: _____ Work Phone _____
Street Address: _____ City _____
Occupation _____ Employer _____
Phone _____ Employer Street Address: _____

Primary Insurance Information

Subscriber Name: (Last, First, Middle) _____ Birthday (MM/DD/YYYY) _____
Relationship to patient _____ Occupation _____
Employer_____ Work Phone _____
Employer Street Address:_____ City _____
Insurance Company _____ ID number_____ Group Number _____
Co-pay $_____ Insurance Street Address: _____

Secondary Insurance Information

Subscriber Name: (Last, First, Middle) _____ Birthday (MM/DD/YYYY) _____
Relationship to patient _____ Occupation _____
Employer_____ Work Phone _____
Employer Street Address:_____ City _____
Insurance Company _____ ID number_____ Group Number _____
Co-pay $_____ Insurance Street Address: _____

Emergency Contact

Contact Name: (Last, First, Middle) _____ Phone Home _____
Phone Mobile _____ Relationship to patient _____
Contact Street Address: _____

Authorization

The patient is under the care and supervision of his/her attending physician and it it the responsibility of the clinic and its nursing staff to carry out instructions of such physician. In accordance with Jamaica Law, I herby consent to and authorize the administration of all medical diagnostic procedures, medical treatments, anesthetics, X-rays examination and surgical procedures deemed necessary by the attending physician for the patient named in this document. In addition, I authorize the release of any medical or any other information necessary to process this claim I also request payment of government benefits to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Patient/Guardian Signature _____

Date _____