PATIENT REGISTRATION - Please Print Clearly

PATIENT NAME ____ HOME PHONE________________
Last First Middle

Patient Address ____
Street City State Zip

Alternate Contact Information: Cell: __________________ Email:___________________________

Patient Date of Birth __________________ Age _________ Sex: Male _______ Female _________ Social Security # ___________________________________ Occupation _______________________ Employer ____ Business Phone ___________________ Name of Spouse ___________________________________ Occupation _______________________ Referring Doctor ___________________________________ Phone ___________________________ Primary Doctor _____________________________________ Phone ___________________________

Insurance Information

- **PRIMARY INSURANCE** ____

Subscriber Name __________________________________ Self____ Spouse ____ Parent ______ Subscriber Birthdate _____________ Member SSN ______________ Group # ________________

- **SECONDARY INSURANCE** ____

Subscriber Name __________________________________ Self____ Spouse ____ Parent ______ Subscriber Birthdate _____________ Member SSN ______________ Group # ________________

In case of emergency, local friend or relative to be notified:

Name____ Phone ________________________

Relationship to patient ____

I understand that my insurance(s) will be filed, as a courtesy, but I remain solely responsible to Jonathan Clavell, MD for all charges incurred. I hereby authorize Jonathan Clavell, MD. and/or it's representative to release any and all information necessary to process my insurance claim(s). I hereby authorize my insurance company(s) to pay benefits directly to Jonathan Clavell, MD. I hereby authorize Jonathan Clavell, MD to release my medical records to other physicians who may also provide medical care to me.

Signature ____ Date _____________________________

Robert J. Cornell, MD, PA
General Adult and Prosthetic Urology