



**ALLIED UROLOGICAL SERVICES, LLC**  
Metropolitan Lithotripter Associates, PC

**Patient Registration**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

Employer \_\_\_\_\_

Patient's Social Security No. \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ I.D. \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Employer \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ I.D. \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Employer \_\_\_\_\_ DOB \_\_\_\_\_

Referring Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Family Physician (if different from above) \_\_\_\_\_

Person to be notified in case of emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

HAVE YOU EVER BEEN TREATED AT MLA? YES / NO DATE \_\_\_\_\_

I hereby request that payment of authorized Medicare or other insurance benefits be made on my behalf to Metropolitan Lithotripter Associates, P.C. for any services furnished me by a physician member of the P.C. I understand that I am financially responsible to Metropolitan Lithotripter Associates, P.C. for charges not covered by this agreement. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or authorized representatives of my insurance company, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_