



METROPOLITAN LITHOTRIPTOR ASSOCIATES, PC

Allied Urological Services, LLC

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 _____