Chicago Prostate Center
PATIENT REGISTRATION

Date: _____

Last Name:_____ First Name:_____ Middle Initial:_ SS#:_____
Address:_____ City:_____ State:_ Zip:_____
County:_____ Date of Birth: _____ Marital Status:_____
E-mail address:_____
Phone:_____ Cell Phone:_____

If you are an out of state patient, please provide an alternate phone number that we may call:
Phone:_____ **Notes: _____**
Employer:_____ Phone Number:_____
Employer Address, City, State, Zip:_____
Race: ☐Amer. Indian or Alaska Native ☐Asian ☐Black or African Amer. ☐Native Hawaiian or Pacific Islander ☐White ☐Other
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino

Name of nearest relative not living with you: _____
Relation:_____ Phone: _____
If necessary, may we call the above relative? ☐Yes ☐No

PHYSICIAN INFORMATION

1. **Primary Care: _____ Phone: _____**
2. **Urologist:_____ Phone:_____**
3. **Cardiologist:_____ Phone:_____**
4. **Other Physician:_____ Phone:_____**

INSURANCE INFORMATION

1. Name of Insurance Company-PRIMARY:_____
Is this an HMO Plan? **Yes** ☐ **No** ☐ (If this is an HMO plan, please bring your referral to your appointment)

******Note: if patient is covered by their spouses insurance, the following information MUST be completed:***
Spouse's name: _____
Spouse's DOB: _____ Spouse's SS#: _____
Spouse's Employer:_____ Phone Number:_____

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2. Name of Insurance Company-SECONDARY:_____
Is this an HMO Plan? **Yes** ☐ **No** ☐ (If this is an HMO plan, please bring your referral to your appointment)

******Note: if patient is covered by their spouses insurance, the following information MUST be completed:***
Spouse's name: _____
Spouse's DOB: _____ Spouse's SS#: _____
Spouse's Employer:_____ Phone Number:_____

May we leave a message for you at home? Yes ☐ No ☐ At work? Yes ☐ No ☐

Patient Signature: ________________________________ Date: ________________