Sheldon J. Freedman, MD., F. A. C. S.
Diplomate American Board of Urology

Date:_____

Patient Registration

Patient Information

Last Name:_____
First Name:_____MI:_____
Address 1:_____
Address 2:_____
City:_____State:_____ZIP:_____
Preferred Phone:_____Type:_____
Alternate Phone:_____Type:_____
Date of Birth:_____
Social Security #:_____
Sex: ☐ Male ☐ Female
Marital Status: ☐ M ☐ S ☐ D ☐ W
Employment: ☐ Employed ☐ Unemployed
☐ Retired ☐ Disabled

If employed,please complete the following information:
Employer Name:_____
Employer Address:_____
City:_____State:_____ZIP:_____
Employer Phone:_____

Spouse or Insured Parent Information

Last Name:_____
First Name:_____MI:_____
Address 1:_____
Address 2:_____
City:_____State:_____ZIP:_____
Preferred Phone:_____Type:_____
Alternate Phone:_____Type:_____
Date of Birth:_____
Social Security #:_____
Sex: ☐ Male ☐ Female

If employed,please complete the following information:
Employer Name:_____
Employer Address:_____
City:_____State:_____ZIP:_____
Employer Phone:_____

Preferred Pharmacy

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Pharmacy Phone:_____

Referred By

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Referral Phone:_____

Family Physician

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Physician Phone:_____

Primary Insurance

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Primary Phone:_____
Insured's Name:_____
(First) (MI) (Last)
ID#:_____Group#:_____

Secondary Insurance

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Secondary Phone:_____
Insured's Name:_____
(First) (MI) (Last)
ID#:_____Group#:_____

Tertiary Insurance

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Tertiary Phone:_____
Insured's Name:_____
(First) (MI) (Last)
ID#:_____Group#:_____

Emergency Contact—Not at Same Address

Name:_____
Relationship:_____
Address:_____
City:_____State:_____ZIP:_____
Contact Phone:_____

I hereby authorize and request my insurance company to pay any and all medical benefits directly to: Sheldon J. Freedman, M.D. I understand that I am financially responsible for any charges not paid by my insurance carrier, and hereby authorize Dr. Freedman's office to release any information necessary to process my claim.

Patient's/Authorized Person's Signature _____