SEATTLE PROSTATE INSTITUTE

# PATIENT REGISTRATION

**(Please bring this completed form and your insurance cards to your appointment.)**

Your Physician:

☐ Dr. Stephen Eulau ☐ Dr. Robert Takamiya ☐ Dr. Brian Lee

## PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Marital Status: S M P D W

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Other _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Alternate Phone: _____ cell / work / other (circle)

E-mail Address: _____

Occupation: _____

Employer: _____

## SPOUSE / LEGAL NEXT OF KIN:

Name: _____ Relationship: _____

Address (if different from patient): _____

_____

Phone(s): _____ _____

Please continue on reverse side

SEATTLE PROSTATE INSTITUTE

# PATIENT REGISTRATION

Please fill in the **complete name, address, and fax number** for all of your physicians who should receive copies of your Seattle Prostate Institute medical reports and follow-up recommendations. Bring this form and your insurance cards to your initial visit.

| | | | |
|---|---|---|---|
| **Primary Care Physician** | Name: | | |
| | Address: | | |
| | City: | State: | Zip: |
| | Phone: | Fax: | |
| | | | |
| **Urologist** | Name: | | |
| | Address: | | |
| | City: | State: | Zip: |
| | Phone: | Fax: | |
| | | | |
| **Other** | Name: | | |
| | Address: | | |
| | City: | State: | Zip: |
| | Phone: | Fax: | |

**How Did You Come To Choose SPI For Your Care?**

| | | | |
|---|---|---|---|
| Referred By A Physician | Name: | | |
| | Address: | | |
| | City: | State: | Zip: |
| | Phone: | Fax: | |
| | | | |
| Learned About SPI From: | Family member: _____<br>Friend: _____<br>The Internet: _____<br>Other (please specify): _____ | | |

_____ _____

Patient Signature Date