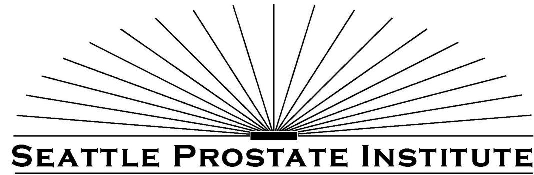


PATIENT REGISTRATION

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

Your Physician:

☐ Dr. Stephen Eulau ☐ Dr. Robert Takamiya ☐ Dr. Daniel Landis

Your appointment date: ___________________________________

PATIENT INFORMATION:

Last Name: ________________________ *First Name:* ______________________ *MI:*_____

Social Security #: ____________________________ *Birth Date:* ____________________

Marital Status: *S* *M* *P* *D* *W*

Race: *Caucasian* *African American* *Asian* *Native American* *Other*________

Mailing Address: ____

City: ______________________________ *State:* _______ *Zip:*________

*Home Phone: (*________*)*_________________________________

*Alternate Phone: (*________*)*_______________________________

E-mail Address: ____

Employer: ____

Occupation: ____

SPOUSE / LEGAL NEXT OF KIN:

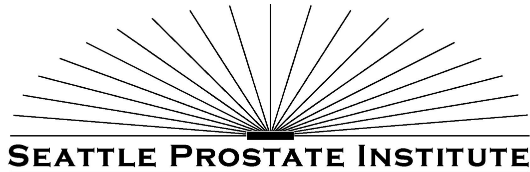
*Name:*_____________________________________ *Relationship:*________________

Address (if different from patient):

____

*Home Phone: (*________*)*_________________________________

Please continue on reverse side



PATIENT REGISTRATION

Please fill in the **complete names, addresses and phone numbers** of the 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:
	Tel: Fax:
Urologist	Name:
	Address:
	City: State: Zip:
	Tel: Fax:
Other	Name:
	Address:
	City: State: Zip:
	Tel: Fax:

How Did You Come To Choose SPI For Your Care?

Referred By A Physician	Name:
	Address:
	City: State: Zip:
	Tel: Fax:
Learned About SPI From:	Family member: ___________________________________ Friend: ____ The Internet: _____________________________________ Other (please specify): ______________________________

____ ________________________

Patient Signature Date