VIRGIN ISLANDS UROLOGIC CENTER, INC.
JOHN RONALD FRANKLIN, M.D.
Patient Registration

Date:_____ DOB:_____

PATIENT
Last Name _____ First Name _____ Middle Initial _____
Mailing Address _____
Physical Address _____
City _____ State_____ Zip_____
Phone Home _____ Work_____ Cell_____
Preferred Message Phone_____ Social Security Number _____
Date of Birth_____ Marital Status_____ Sex_____
Employer_____
Have you been seen at V.I. Urologic Center in the past 3 years? _____
Primary Doctor _____ Referring Doctor _____

HEALTH INSURANCE
DO YOU HAVE MEDICARE, PART B? _____
Primary Insurance _____Effective Date _____
Group Number _____ Subscriber Number _____
Policy Holder Name _____ Date of Birth _____
Employer _____ Relationship to Patient_____
Secondary Insurance _____ Effective Date _____
Group Number _____ Subscriber Number _____
Policy Holder Name_____ Date of Birth _____
Employer _____ Relationship to Patient_____

RESPONIBLE PARTY
Last Name _____ First Name _____ Middle Initial _____
Mailing Address _____
Physical Address _____
City _____ State_____ Zip_____
Phone Home _____ Work_____ Cell_____
Preferred Message Phone_____ Social Security Number _____
Date of Birth_____ Marital Status_____ Sex_____
Employer_____

IN CASE OF EMERGENCY
Last Name_____ First Name_____ Phone Number_____
Relationship to Patient_____

2Nd Contact
Last Name_____ First Name_____ Phone Number_____
Relationship to Patient_____

I certify that the above information provided on this form is accurate. I further authorize the release of any medical or other information necessary to process all of the insurance claims. I also request payment of insurance and/or government benefits directly to Dr. Franklin, the party who accepts assignments. Such payments should not exceed my indebtedness to Dr. Franklin. I further authorize a copy of this authorization to be used in place of the original.

Signature:_____ Date: _____