John M Cannon, MD
Urology and Urologic Surgery
PATIENT REGISTRATION

First Name _____ Middle _____ Last Name _____

Street Address _____ City _____ State ___ ZIP _____

Cell Phone: # _____ May Confidential messages be left here? Y N **OK to Text?** Y N

Home Ph: # _____ May Confidential messages be left here? Y N

Email: _____ May Confidential messages be left here? Y N

Date of Birth: _____ Sex: M F LAST 4 digits of SSN: _____

Employer: _____ Religious Denomination: _____

Marital Status: M S W S/D Spouse's name _____

Primary Care Doctor: _____ Previous Urologist: _____

Pharmacy Name: _____ Pharmacy Location: _____

Practice Billing and Payment Notification:
I authorize the release of any information necessary to process claims and the payment of all medical benefits to John M Cannon, MD for professional services rendered. I accept responsibility for any payment not covered by my medical insurance (or disability or workman's comp insurance) and give permission for the practice to call me at home or cell phones regarding any billing issues. I am aware that co-payment and payment arrangements are due at time of service. The Practice reserves the right to charge administrative fees for late payments or post postponed co-payments.

Signature of Patient/Pt Rep./Guardian: _____ Date: _____

HIPAA:
To Facilitate our efforts to communicate with you, please list the names, phone numbers and relationship of family and friends to whom we are authorized to disclose your *Protected Health Information*.

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Notice of Privacy Practices acknowledgment RECEIPT
I agree that I was provided an opportunity to read the *Notice of Privacy Practices* for John M Cannon, MD.

Signature of Patient/Pt Rep./Guardian: _____ Date: _____

For Office use:
Information Reviewed _____ _____ _____
initial & date *initial & date* *initial & date*