



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





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:	_____	
	Friend:	_____	
	The Internet:	_____	
	Other (please specify):	_____	

Patient Signature

Date