DALE R. TRAFICANTE, M.D., F.A.C.S.

UROLOGY

Board Certified Urologist

REGISTRATION INFORMATION

Nick name: _____ **DATE:** _____

LEGAL NAME: _____ _____ _____ _____**SS#** _____
FIRST MIDDLE LAST SUFFIX

LOCAL ADDRESS: _____ **CITY:** _____ **ZIP:** _____

OTHER ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP:** _____

PHONE: HOME: _____ **WORK:** _____ **CELL** _____

MARRIED SINGLE WIDOW MINOR **DATE OF BIRTH:** _____ **AGE:** _____

SEX: M F **ETHNICITY:** HISPANIC/LATINO NOT HISPANIC/LATINO

RACE: ASIAN AMERICAN INDIAN/ALASKA NATIVE BLACK/AFRICAN AMERICAN WHITE

EMAIL ADDRESS: _____

EMPLOYER: _____ **OCCUPATION**: _____

PHONE NUMBER: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ PHONE: _____

PURPOSE OF YOUR VISIT: _____

REFERRED BY: _____ PHONE: _____

FAMILY PHYSICIAN: _____PHONE: _____

PHARMACY: _____ PHONE: _____

NAME OF PRIMARY INSURER: _____

INSURANCE ID #: _____**GROUP#**: _____

*Please complete the following if the patient is **not** the primary card holder.*

PRIMARY INSURED'S NAME_____BIRTHDATE_____

RELATIONSHIP TO PATIENT_____SOCIAL SECURITY NUMBER_____

NAME OF SECONDARY INSURER: _____

INSURANCE ID #: _____**GROUP#:** _____