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_____

PHONE: HOME: _____ WORK: _____ CELL _____

MARRIED___ SINGLE___ DIVORCED___ 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 :(___)_____

NAME OF PERSON NOT LIVING WITH YOU: _____

RELATIONSHIP: _____PHONE :(____)_____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU: _____

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#: _____