Urology Associates, Inc.

Patient Information

First Name_____ Last Name_____ M.I._____

Street Address_____ City_____ State_____ Zip_____

Social Security #_____ Male_____ Female_____ Date of Birth_____

Marital Status (circle one): Single Married Divorced Widowed Partner E-mail address_____

Race (circle one): White Black Hispanic Native American Asian Other (please specify)_____
Preferred Language (if other than English) _____

Home Phone _____ Work Phone_____ Cell/Other_____

Employer Name_____ Employer Phone_____ Occupation_____

Employer Address_____ If Student: Full Time___ Part Time___

Spouse/Nearest Relative

Name_____ DOB_____ Relationship to patient_____

Address_____ Employer_____

Home Phone_____ Work Phone_____ Cell/Other_____

Emergency Contact

Name_____ DOB_____ Relationship to patient_____

Home Phone_____ Work Phone_____ Cell/Other_____

Insurance Information

Primary Insurance_____ ID#_____ Group#_____

Subscriber Name_____ Subscriber DOB_____ Relationship to patient

Secondary Insurance_____ ID#_____ Group#_____

Subscriber Name_____ Subscriber DOB_____ Relationship to patient_____

Other Information

Pharmacy Name, Location and Phone Number_____

Referring Doctor_____ Primary Care Doctor_____

Authorization: I certify that the information on this form is true and accurate to the best of my knowledge. I also understand that this information may be used by Urology Associates to establish primary insurance coverage and to answer questions the insurance carriers listed may have regarding pre-existing conditions. I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Urology Associates, Inc. or any individual provider it may designate for services rendered.

Privacy Notice Acknowledgement : I understand that Urology Associates, Inc. has a published Privacy Policy and that I am entitled to a copy at my request.

Financial Policy **Acknowledgement:** I have been provided a copy of Urology Associates' Financial Policy. I have read and agree to the terms of the policy.

Signature of Patient or Parent/Guardian of Minor_____Date_____

Urology Associates, Inc.

In the event that a patient wishes another individual to receive medical information such as test results, etc., or in the event that the patient is unable to receive those results, the patient may choose to designate persons who are authorized to receive that information.

I hereby authorize the release of my medical health information to the following designated persons:

( ) Spouse Name _____

( ) Son Name _____

( ) Daughter Name _____

( ) Parent Name _____

( ) Other Name _____

** Permission to leave lab/test results on my answering machine or voice mail: (Please circle) Yes No

I understand that if I wish to revoke this authorization at any time, the request for revocation must be made in writing to Urology Associates, Inc.

If I do not indicate a designated person to receive information, I am requesting that medical information be released only to me.

Patient Signature _____

Printed Name _____

Date _____