

# UROLOGY ASSOCIATES LTD., S.C.

## PATIENT INFORMATION

PLEASE PRINT

DR. \_\_\_\_\_ DATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

NAME \_\_\_\_\_

EMPLOYERS PHONE NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMPLOYERS ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

### **INSURANCE INFORMATION**

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

POLICY NO(S). \_\_\_\_\_ GRP.# \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

INSURED'S NAME IF NOT PATIENT (BELOW)

**SOCIAL SECURITY NO.** \_\_\_\_\_

\_\_\_\_\_ BIRTHDATE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

### **SECONDARY INSURANCE**

SPOUSE \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_

POLICY NO(S). \_\_\_\_\_ GRP. # \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

INSURED'S NAME IF NOT PATIENT (BELOW)

REFERRED BY \_\_\_\_\_

\_\_\_\_\_ BIRTHDATE \_\_\_\_\_

**MAY WE LEAVE MESSAGES REGARDING YOUR HEALTH CARE ON YOUR HOME OR CELL PHONE?** \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_ **PHONE NUMBER** \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST FOR PHOTOSTATIC COPY.**

**WHAT ALLERGIES DO YOU HAVE?** \_\_\_\_\_

(PLEASE READ AND SIGN)

ALL PROFESSIONAL SERVICES RENDERED ARE PAYABLE BY THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IF NO INSURANCE COVERAGE, IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE UROLOGY ASSOCIATES, LTD., S.C., TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO UROLOGY ASSOCIATES LTD., S.C., ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

IF I HAVE MEDICARE, I UNDERSTAND THAT I AM RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE (IF NOT COVERED BY SECONDARY INSURANCE.)

**SIGNATURE OF PATIENT (OR PARENT)** \_\_\_\_\_ **DATE** \_\_\_\_\_

IF PATIENT IS A CHILD PLEASE COMPLETE THE FOLLOWING:

FATHER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

MOTHER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_