Patient Information

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip Code _____

Street Address (if different) _____ City _____ State _____

Zip Code _____ Email _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employers Name and Address _____

Insured Name (if different than patient or if patient is a minor)

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip Code _____

Relationship to Patient _____ Marital Status ___ S ___ M___ D___ W

Spouse's Name _____

Employer's Name and Address _____
_____

Insurance

(Please bring your Driver's License and Insurance Cards to your appointment)

Primary _____ Secondary _____

ID Number _____ ID Number _____

Group Number _____ Group Number _____

THE FOLLOWING INFORMATION IS MANDATORY

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Emergency contact not living with you? _____ Phone _____

How Did You Hear About Us? _____

I hereby authorize Advanced Urological Care to provide medical treatment services to me and/or my dependents, and to use my Personal Health Information to file a claim for service with my insurance company. In doing so, I assign to the physician all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit and that payment is due at the time of my visit.

Signature _____ Date _____