

**PATIENT INFORMATION**

Single ( ) Married ( ) Divorced ( ) Separated ( ) Widow(er) ( )

Name \_\_\_\_\_  
Last First Initial Birth Date

Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
City State Zip Code

Patient Social Security # \_\_\_\_\_ Is the Patient a student? No \_\_\_ Yes \_\_\_ Full Time \_\_\_ Part Time \_\_\_

Employer \_\_\_\_\_  
Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Employer's Phone \_\_\_\_\_  
City State Zip Code

Referred to Urology Associates by \_\_\_\_\_

Please list an Emergency Contact Name & Telephone: \_\_\_\_\_

**SPOUSE INFORMATION**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Social Security # \_\_\_\_\_

Employer \_\_\_\_\_  
Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Employer's Phone \_\_\_\_\_  
City State Zip Code

**INSURANCE INFORMATION**

PRIMARY INSURANCE CARRIER \_\_\_\_\_

Address \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy # \_\_\_\_\_

How is patient related to Policy Holder? Self  Spouse  Child

SECONDARY INSURANCE CARRIER \_\_\_\_\_

Address \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy # \_\_\_\_\_

How is patient related to Policy Holder? Self  Spouse  Child

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims.  
The patient (or legal guardian) is responsible for all fees, regardless of insurance coverage.

**I ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES TO UROLOGY ASSOCIATES:**

(Patient or legal guardian signature) \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_