PATIENT INFORMATION

PLEASE PRINT OR WRITE LEGIBLY **PLEASE ANSWER ALL QUESTIONS**

Patient's Name	*Date of Birth*	*Age*

Street Address, Route, P.O. Box	*City*	*State*	*ZIP*

Social Security Number	*Marital Status* S____ M____ W____ D____	*Email*

Home Phone	*Cell Phone*	*Carrier*

Patient's Employer	*Occupation*	*Business Phone*

Spouse's Name	*Spouse's Employer*	*Business Phone*

PLEASE FILL OUT IF PATIENT IS A MINOR

Parent's Name	*Address*	*Home Phone*

Mother's or Father's Employer	*Business Phone*

PERSON TO CONTACT OUTSIDE OF HOUSEHOLD IN CASE OF EMERGENCY

Name	*Phone Number*

IF YOU WERE REFERRED TO US BY ANOTHER DOCTOR, PLEASE LIST PHYSICIAN'S NAME

Do you have any allergies to medications? Please list them

Do you have any allergies to iodine?

Have you ever had any problems with any x-ray studies?

Are you taking any medications now? Please list them.

_____ _____ _____

_____ _____ _____

_____ _____ _____

INSURANCE INFORMATION

Medicare Number	*Medicaid Number*

Name of insurance company	*ID or Policy No.*	*Group No.*	*Subscriber*

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of any medical information necessary to process insurance claims.

SIGNED _____ Date _____

AUTHORIZATION TO PAY INSURANCE BENEFITS AND/OR GOVERNMENT BENEFITS

I authorize payment directly to the doctors of Urology Care, Inc. I am financially responsible for charges not covered.

SIGNED _____ Date _____