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	Home Phone	

Marital Status S____ M____ W____ D ____	Social Security Number

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 ______________