



STACY J. CHILDS, M.D., F.A.C.S.
JAMIE VANOVEREN, D.O.

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Last Name _____ First Name _____ Middle Initial _____ Birth date ____/____/____
Mailing Address _____ City _____ State _____ Zip _____
Phone (____) _____ Cell Phone (____) _____ Social Security # _____ Sex _____
Marital Status _____ Referring Physician _____ Pharmacy _____
Employer _____ Phone _____
Emergency Contact _____ Phone _____
Spouse's Name _____ Social Security # _____ Birth date _____

Responsible person for account if different than patient

Name _____ Social Security # _____ Birth date ____/____/____
Address _____ City _____ State _____ Zip _____ Phone (____) _____

INSURANCE INFORMATION

Insurance # 1 _____
PRIMARY CARDHOLDER NAME _____ DATE OF BIRTH ____/____/____
Relationship to Patient _____ INS ID# _____ Group# _____
Insurance # 2 _____

FINANCIAL OBLIGATIONS

I have been given the opportunity to read and review Urology Clinic P.C.'s financial policy. I understand that I am responsible for payment in full of all charges incurred, including costs not covered by my insurance, I further understand I am responsible for contacting and /or following up with my insurance company should they not pay in a timely manner.

* _____

Signature of Patient (or guardian if minor) _____ **Date** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given the opportunity to read a copy of Urology Clinic P.C.'s Notice of Privacy Practices (HIPPA). **Urology Clinic P.C. can release my health information or billing to the following.**

(NAME of person) _____ **Relation** _____

(NAME of person) _____ **Relation** _____

* _____

Signature of Patient (or guardian if minor) _____ **Date** _____

Printed Name _____