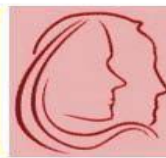




**Urology**  
Clinic P.C.



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 Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex \_\_\_\_\_

Marital Status: S  M  D  W  Preferred Language **English** **Other** \_\_\_\_\_ **Decline**

Race \_\_\_\_\_ **Decline**  Ethnicity **Hispanic** **Non Hispanic** **Decline**

Preference for appointment reminders **Printed** **Electronic** **Phone** **Email address** \_\_\_\_\_

Family Physician \_\_\_\_\_ Pharmacy \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Contact (not living with you) Name:** \_\_\_\_\_ **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 IF DIFFERENT THAN PATIENT**

PRIMARY CARDHOLDER NAME \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

**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 of billing to the following.**

(NAME of person) \_\_\_\_\_ Relation \_\_\_\_\_

(NAME of person) \_\_\_\_\_ Relation \_\_\_\_\_

\*

\_\_\_\_\_  
Signature of Patient (or guardian if minor) Date

Printed Name \_\_\_\_\_