Urology Clinic P.C.

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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_____Spouse's Name_____

Employer_____ Phone _____

Emergency Contact (not living with you) Name_____ Phone_____

RESPONSIBLE PERSON FOR ACCOUNT IF DIFFERENT THAN PATIENT

Name _____ Social Security # _____ Birth date_____

Address_____ City_____ State____ Zip_____ Phone(___)_____

INSURANCE INFORMATION IF DIFFERENT THAN PATIENT

IF YOU ARE NOT THE INSURED YOU ARE REQUIRED ** TO FILL OUT BELOW**

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. Urology Clinic PC will charge a $50 fee for no show of appointments or canceling appointment less than 24 business hours before scheduled appointment.

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).

*_____ _____

Signature of Patient for HIPPA and FINANCIAL OBLIGATIONS (or guardian if minor) **DATE**

AUTHORIZATION TO SHARE YOUR MEDICAL INFORMATION

I authorize Urology Clinic P.C. to share medical information with my designated person (e.g. your partner, spouse, relative or friend.) You can appoint several persons if you want to, or leave it blank. If someone calls or comes in to ask for any information about you, the name of this person must be on this form, if not; we cannot and will not give any information.

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**