

# 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
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## 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 \_\_\_\_\_