

# NORTHWEST UROLOGICAL CLINIC, P.C.

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DATE \_\_\_\_\_  
ALLERGIES \_\_\_\_\_  
HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

ACCOUNT NO. \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
REFERRING DOCTOR \_\_\_\_\_  
REFERRING DR'S PHONE NO. \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
last first middle

Patient's address: \_\_\_\_\_  
street city state zip

Home phone number: \_\_\_\_\_ Daytime No: \_\_\_\_\_ Cell: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Sec No: \_\_\_\_\_ Marital status: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

IF CHILD: Mothers name: \_\_\_\_\_ Fathers name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's address: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Phone number: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PRIMARY INSURANCE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

SUBSCRIBER NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

GUARANTOR: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

GUARANTOR'S DOB: \_\_\_\_\_ SOCIAL SEC NO: \_\_\_\_\_

SECONDARY INSURANCE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

SUBSCRIBER NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

GUARANTOR: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

GUARANTOR'S DOB: \_\_\_\_\_ SOCIAL SEC NO: \_\_\_\_\_

Payment may be requested in advance if information in boxed area is not supplied.

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. If your plan requires a referral from your primary care physician and one is not on file with the insurance company you are responsible. The clinic collection policy is available upon request.

I authorize release of information in my medical history to medicare and/or my insurance company and assign to the physician all payments for medical services rendered to my dependants or myself. I understand that I am responsible for any amount not covered by insurance.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_