

**Urology One, Inc.**

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Area Code/Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Marital Status: S M D W (Circle One) Race: \_\_\_\_\_  
Parents' Name or Spouse: \_\_\_\_\_  
Allergies (including medications): \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

**Billing Information:** Name, Address and Phone of responsible party, **if other than patient:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\*\*\*\*\*

Is your spouse employed? \_\_\_\_\_ Are you covered under spouse's insurance? If so, please list it below.  
Spouse's date of birth: \_\_\_\_\_  
Medicare Patients Medicare #: \_\_\_\_\_ Part A? \_\_\_\_\_ Part B? \_\_\_\_\_  
Is Medicare your primary insurance? \_\_\_\_\_ If not, please list your primary insurance below.

**RECORD AUTHORIZATIONS**

Please list below, the name of who we may disclosure health information to on a regular basis:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE AUTHORIZATION**

**Medicare**

I request that payment of authorized medicare benefits be made either to me or on my behalf to Urology One, Inc. for any service furnished me by their physicians. I authorize release to the health care financing administration and its agents any medical information about me needed to determine theses benefits payable for related services.

\_\_\_\_\_  
Signature

**All Other Insurance**

I hereby authorize Urology One, Inc. to submit to my insurance carrier or its intermediaries for all covered services rendered by Urology One, Inc. and direct my insurance carrier or its intermediaries to issue payment checks directly to Urology One, Inc. for any services that have not been paid.

This assignment will remain in effect until revoked by me in writing. A photocopy of this is valid as the original. I understand I am responsible for all charges whether or not paid by insurance. I authorize Urology One, Inc. to release information necessary to secure payment.

\_\_\_\_\_  
Signature

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

NAME OF INSURANCE COMPANY: \_\_\_\_\_  
INSURED NAME: \_\_\_\_\_  
POLICY OR ID#: \_\_\_\_\_  
INSURANCE GROUP # OR NAME: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
INSURANCE PHONE #: \_\_\_\_\_

**SECONDARY INSURANCE**

NAME OF INSURANCE COMPANY: \_\_\_\_\_  
INSURED NAME: \_\_\_\_\_  
POLICY OR ID#: \_\_\_\_\_  
INSURANCE GROUP # OR NAME: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
INSURANCE PHONE #: \_\_\_\_\_

**IF YOU HAVE ANY OTHER INSURANCE, PLEASE LIST HERE.**

NAME OF INSURANCE COMPANY: \_\_\_\_\_  
INSURED NAME: \_\_\_\_\_  
POLICY OR ID#: \_\_\_\_\_  
INSURANCE GROUP # OR NAME: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
INSURANCE PHONE #: \_\_\_\_\_