

Urology Professional Association Patient Information Form

Med Rec # _____

Patient Information

Legal Name _____ Date of Birth _____
(Last) (First) (Middle)

Mailing Address _____

City _____ State _____ Zip _____

Physical Address (if different from mailing) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Sex: M / F Marital Status: S / M / D / W

Employer _____ City _____

Spouse _____

If a physician or other medical provider referred you, who referred you _____

Parent or other Responsible Party if other than patient

Legal Name _____ Date of Birth _____
(Last) (First) (Middle)

Mailing Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Sex: M / F Marital Status: S / M / D / W

Employer _____ City _____

Insured Information if Insured Is Not Patient nor Responsible Party

Insured's Name _____ Date of Birth _____

Insured's Social Security # _____

Insured Phone Number _____

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Notice of Privacy Practices: I acknowledge I have been offered a copy of Urology's Notice of Privacy Practices
Signature _____

(please sign this at check in where you will be given a copy of our Notice of Privacy Practices)

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I authorize the staff at Urology to discuss my medical information with the following persons. This authorization shall remain in effect until such time as it is withdrawn by me in writing.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

.....
Emergency Contact Information

Name _____ Phone number(s) _____

Please see financial policy with signature section.