NEW PATIENT INFORMATION

ACCOUNT # _____

HOW WERE YOU REFERRED? ❒ Primary Doctor ❒ Specialist Doctor _____ ❒ Friend ❒ Insurance ❒ Other _____
Referring Doctor Phone Number ( ) _____

Patient Last Name	First Name	Initial	Sex	Age	Marital Status S M W D Sep	Birthdate	Home Phone ( )
Address	Apt	City	State	Zip			Cell Phone ( )
E-mail address					Social Security #		Driver's License #
Employer - If Minor, Give Parent's Information					Occupation (Parent If Student)		Business Phone ( )
Employer Address			City		State	Zip	
Pharmacy Name					Pharmacy Phone ( )		Pharmacy FAX ( )
Spouse Last Name	First Name	Initial			Social Security #		Birthdate

PERSON OR COMPANY RESPONSIBLE FOR PAYMENT:

Last Name	First Name	Initial	Relationship to Patient	
Address			Home Phone ( )	Social Security #
City	State	Zip	Work Phone ( )	Driver's License #
Nearest Family Member Not Residing With You:	Relationship	Street / City / State / Zip		Phone

IN CASE OF EMERGENCY CONTACT:

Last Name	First Name	Initial	Relationship to Patient	Telephone

HEALTH INSURANCE INFORMATION:

1st Insurance Company Name	Name of Insured	Social Security #	Birthdate / /
Send Claim To:	**Employer**		Relationship to Insured Self Spouse Parent Employer Other
City State Zip	Employer Address		Group # Policy or Certificate #
2nd Insurance Company Name	Name of Insured	Social Security #	Birthdate / /
Send Claim To:	**Employer**		Relationship to Insured Self Spouse Parent Employer Other
City State Zip	Employer Address		Group # Policy or Certificate #

Payment for Today's Visit: ❒ Cash ❒ Check ❒ Visa ❒ Mastercard ❒ American Express ❒ Discover	
Name on Card # Expires	
Is your present condition the result of: ❒ Automobile Accident ❒ On-the-job Injury	Date of Injury
If X-rays have been taken for this problem, where were they taken?	Date of X-Rays

All professional services rendered are charged to the patient and remain the patient's responsibility regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

HMO & PPO PATIENTS: It is the patient's responsibility to have any required referral from the primary care doctor and to furnish complete insurance information for this office. If the insurance information or referral is not available, the patient will be responsible for the charges and payment in full will be collected.

DATE _____ PATIENT / OTHER LEGALLY RESPONSIBLE PERSON (Signature) _____

AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I authorize you to give me reasonable and proper medical care by today's standards.

I authorize Urology Clinics of North Texas, P.A. to obtain any X-ray films or laboratory results needed for my treatment.

I hereby authorize Urology Clinics of North Texas, P.A. to release all medical information required by my insurance company and others to file for medical benefits or otherwise collect on my account. I also authorize Urology Clinics of North Texas, P.A. to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize payment of all benefits to the physician(s).

DATE _____ PATIENT / OTHER LEGALLY RESPONSIBLE PERSON (Signature) _____