Urologic Patient Information Form

Patient Information Med Rec #_____

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

Mailing Address _____

Physical Address (if different from mailing) _____

Home Phone _____ Cell Phone _____ Work Phone _____

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

Employer _____ City _____

Spouse _____ Spouse Soc Sec # _____

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

Race (circle one): American Indian or Alaskan Native / Asian / Black or African American /
Native Hawaiian or other Pacific Islander / White

Ethnicity (circle one): Hispanic / Non Hispanic

Preferred Language (circle one if preferred): English / Spanish / Other _____

Email address: _____

Preferred Method of contact (circle one): Phone – Home or Cell / Mail / Email

Preferred Pharmacy/Location _____

Parent or other Responsible Party if other than patient

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

Mailing Address _____

Home Phone _____ Cell Phone _____ Work 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's Phone Number _____ Employer_____

Notice of Privacy Practices

I acknowledge I have been offered a copy of Urologic's Notice of Privacy Practices:

Signature _____

Release of Medical Information

I authorize the staff at Urologic 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 This authorization shall remain in effect until such time as it is withdrawn by me in writing.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 _____ Phone _____

_____ Relationship _____ Phone _____

Emergency Contact Information (must be someone listed above)

Name _____ Phone number(s) _____

Telephone Consent

I understand the Clinic or its agents may use prerecorded/artificial voice messages and/or auto dialing devices to remind me about appointments or notify be of other information and I expressly consent to the Clinic or its agents use of any number associated with my account, including wireless numbers, including contact done by prerecorded/artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account.

Signature _____ Date _____