

Southwest Urology, Inc.

Date: _____

PATIENT NAME: _____ AGE: _____ MALE: _____ FEMALE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

AREA CODE/PHONE NO: _____ DATE OF BIRTH: _____

SOCIAL SEC. #: _____ MARITAL STATUS: S M D W (Circle one)

PARENTS' NAMES OR SPOUSE: _____

KNOWN MEDICAL PROBLEMS: _____

ALLERGIES: _____

REASON FOR VISIT: _____

FAMILY DOCTOR: _____ REFERRED BY: _____

EMPLOYER: _____ EMP. PHONE: _____ OCCUPATION: _____

BILLING INFORMATION: NAME, ADDRESS AND PHONE OF RESPONSIBILITY PARTY, IF OTHER THAN PATIENT:

IN CASE OF EMERGENCY NOTIFY: _____ PHONE NO: _____

.....
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.

INSURANCE AUTHORIZATION

MEDICARE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO SOUTHWEST UROLOGY 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 THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE

ALL OTHER INSURANCE

I HEREBY AUTHORIZE SOUTHWEST UROLOGY, INC. TO SUBMIT TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES FOR ALL COVERED SERVICES RENDERED BY SOUTHWEST UROLOGY, INC. AND DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECKS) DIRECTLY TO SOUTHWEST UROLOGY, 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 SOUTHWEST UROLOGY, INC. TO RELEASE INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNATURE

(IF YOUR INSURANCE CARDS WERE COPIED BY THE SECRETARY, YOU DO NOT NEED TO COMPLETE THE NEXT SECTION.)

INSURANCE INFORMATION

PRIMARY INSURANCE:

NAME OF INSURANCE COMPANY: _____

INSURED NAME: _____

POLICY OR ID #: _____

INSURANCE GROUP # OR NAME: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE #: _____

PRE-ADMISSION CERTIFICATION REQUIRED? _____

SECONDARY INSURANCE:

NAME OF INSURANCE COMPANY: _____

INSURED NAME: _____

POLICY OR ID #: _____

INSURANCE GROUP # OR NAME: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE #: _____

PHONE # FOR PRE-CERTIFICATION? _____

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 #: _____

PRE-ADMISSION CERTIFICATION REQUIRED? _____

PHONE # FOR PRE-CERTIFICATION? _____