PATIENT INFORMATION FORM

Please do not hesitate to contact us, regarding your appointment or directions to our office. We appreciate your cooperation in completing this form.

GENERAL INFORMATION

Last Name: ____

First Name: _______________________________________

Middle: ____

Marital status:

__ Single __ Married __ Divorced

__ Separated __ Widowed

Birth date: __________________ **Sex:** __ M __ F

Street address/PO Box:

____

City: ___________________ **State:** _______ **Zip:** _________

Email address:

____

Social Security #: __________________________________

Ethnicity:

__ Hispanic __ Non-Hispanic

Race:

__ African-American __ Caucasian __ Asian

__ American Indian __ Other

Cell/Mobile Phone:

(_______) ____________________________ Preferred? __

Home Phone:

(_______) ____________________________ Preferred? __

Work Phone:

(_______) ____________________________ Preferred? __

Employer Name:

____

Employer Address:

____

Occupation::

____

Pharmacy Name:

____

Pharmacy Address:

____

Pharmacy Phone:

(_______) ______________________________________

Pharmacy Fax:

(_______) ______________________________________

REFERRAL SOURCE

Referring Source (Please check all that apply):

__ Physician/Clinic __ Family/friend

__ Employer/Coworker __ Insurance

__ No referring MD __ Self __ Other: _____________

__ (Please check if this is a **second opinion**)

Referral Name:

____

Referral E-mail:

____

Referral Address:

____

Referral Phone:

(_______) ___________________________________

Referral Fax:

(_______) ___________________________________

INSURANCE INFORMATION

Person responsible for bill:

____________________________________ Self ___

Birth date: ________________

Street address/PO Box (if different):

____

City: ________________ **State:** ______ **Zip:** ________

Home Phone:

(_______) ___________________________________

Occupation::

____

Employer:

____

Employer Address:

____

Employer Phone:

(_______) ___________________________________

Name of primary insurance:

____

Subscriber's name:

______________________________________ Self ___

Birth date: ________________

Policy #: _______________ **Group #:** ______________

Patient's relationship to subscriber:

___ Self ___ Spouse ___ Child ___ Other

SECONDARY INSURANCE (IF APPLICABLE)

Name of secondary insurance:

____

Subscriber's name:

______________________________________ Self ___

Birth date: ________________

Policy #: _______________ **Group #:** ______________

Patient's relationship to subscriber:

___ Self ___ Spouse ___ Child ___ Other

IN CASE OF EMERGENCY

Please notify in case of emergency:

____

Relationship to patient:

____

___ Check if address is the **same** as in patient information

Street address/PO Box:

____

City: ________________ **State:** ______ **Zip:** ________

Home Phone:

(_______) ___________________________________

Work/Cell Phone:

(_______) ___________________________________

OTHER TREATING PHYSICIANS

Primary Care Physician:

____

_

Address:

____

_

Phone:

(________)

____

Fax:

(________)

____

Conditions Treated:

____

_

SPECIALIST PHYSICIAN(S)

Physician name:

____

_

Specialty/Conditions Treated:

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Address:

____

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Phone:

(________)

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Fax:

(________)

____

Physician name:

____

_

Specialty/Conditions Treated:

____

_

Address:

____

_

Phone:

(________)

____

Fax:

(________)

____

Physician name:

____

_

Specialty/Conditions Treated:

____

_

Address:

____

_

Phone:

(________)

____

Fax:

(________)

____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize the OKC Kids Urology and/or insurance company to release any information required to process my claims.

Parent/Guardian Signature:

____

_

Date:

____

Personal Representative Name:

____

_

Personal Representative Authority:

____

_

Responsible Party Signature:

____

_