PATIENT INFORMATION

Patient Name	Account #	Date of Birth (DOB)	
Home Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip
Daytime Phone	Evening Phone		

Sex ❑ Male ❑ Female	Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	Spouse's name	Healthcare Proxy ❑ Yes ❑ No

Social Security Number (SSN)	Driver's License #	E-mail address (optional)

Who Referred You? If a physician, give full name and phone number also.

EMPLOYMENT INFORMATION

Employed ❑ Yes ❑ No	Employer (Parent's employer if minor)	Occupation
Employer's Address	City, State, Zip	Phone
Spouse's Employer		Spouse's SSN
Spouse's Employer Address	City, State, Zip	Phone

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses	Relationship to patient	Phone	
Address	City	State	Zip

Payment for Today's Visit: ❑ cash ❑ check ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover
Name on card: # Expires:

PRIMARY INSURANCE INFORMATION

Insurance Company	Policy Number	Medicare Number	Medicaid Number

Subscriber's name Subscriber's DOB and SSN	Subscriber's Relationship to patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other:

Address of Insurance Company

SECONDARY INSURANCE INFORMATION

Insurance Company	Policy Number	Medicare Number	Medicaid Number

Subscriber's name Subscriber's DOB and SSN	Subscriber's Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other:

Address of Insurance Company

EMERGENCY INFORMATION

Person to Contact in Case of Emergency, Other than Spouse	Relationship to Patient	Phone

AUTHORIZATION

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.
I authorize you to give me reasonable and proper medical care by today's standards. I authorize Dallas Urology Associates, LLP to release all medical information required by my insurance company and others to file for medical benefits. I authorize Dallas Urology Associates, LLP 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).

Patient's Signature	Date	Legally Responsible Person's Signature	Date