

ACCOUNT #

PEDIATRIC UROLOGY ASSOCIATES, LTD.

DATE:

LOCATION

PLEASE PRINT**PATIENT INFORMATION**

PATIENT NAME		DATE OF BIRTH	AGE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
ADDRESS		CITY	STATE	ZIP	
RACE	ETHNICITY		LANGUAGE		
FATHER			MOTHER		
HOME PHONE	CELL PHONE		HOME PHONE	CELL PHONE	
FATHER'S WORK PHONE			MOTHER'S WORK PHONE		
FATHER'S EMAIL			MOTHER'S EMAIL		
FATHER'S SOCIAL SECURITY #	FATHER'S DOB		MOTHER'S SOCIAL SECURITY #	MOTHER'S DOB	
ADDRESS IF DIFFERENT FROM PATIENT			ADDRESS IF DIFFERENT FROM PATIENT		
CITY	STATE	ZIP	CITY	STATE	ZIP
OCCUPATION			OCCUPATION		
EMPLOYER			EMPLOYER		
LEGAL GUARDIAN					

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY & <u>COMPLETE ADDRESS</u>	SECONDARY INSURANCE COMPANY & <u>COMPLETE ADDRESS</u>
CO-PAY AMOUNT \$	CO-PAY AMOUNT \$
I.D. #	I.D. #
GROUP #	GROUP #
POLICY HOLDERS NAME	POLICY HOLDERS NAME

WHO REFERRED YOU TO OUR OFFICE:

NAME OF FAMILY PHYSICIAN OR PEDIATRICIAN:

NAME, ADDRESS & PHONE # OF FRIEND OR RELATIVE NOT LIVING WITH YOU:

1. I authorize the release of any medical information necessary to process this claim.

2. I authorize payment of medical benefits to undersigned physician or supplier for service described below.

3. I hereby authorize Robert B. Bailey, Jr., M.D., Luis Argueso, M.D., Michael L. Ritchey, M.D., Michael T. Nguyen, M.D., Zachary V. Zuniga, M.D., Marilyn L. Tigges, PA-C, Kelly M. Parker, PA-C, Karen R. Dunivant, CPNP to treat the above named patient and will assume full responsibility for payment of all services rendered unless otherwise arranged for and agreed upon. In the event of default, I also agree to pay for collection costs and reasonable attorney's fees that may be required to effect collection of this account.

SIGNATURE: _____ DATE: _____

(parent or legal guardian if patient is a minor)