

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	
<b>FATHER</b>			<b>MOTHER</b>		
HOME PHONE	CELL PHONE		HOME PHONE	CELL PHONE	
FATHER'S WORK PHONE			MOTHER'S WORK PHONE		
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		
EMPLOYER ADDRESS			EMPLOYER ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
LEGAL GUARDIAN					

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY & <b>COMPLETE ADDRESS</b>		SECONDARY INSURANCE COMPANY & <b>COMPLETE ADDRESS</b>	
CO-PAY AMOUNT \$		CO-PAY AMOUNT \$	
I.D. #	DEDUCTIBLE: _____	I.D. #	
GROUP #	PERCENTAGE: _____	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, Diana L. Braskett, RN, 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)