

**PATIENT INFORMATION**

Please complete all information

Today's Date: / /

Have you ever been a patient with Spokane Urology in the past?  Yes  no Dr: Yr:

Referring Physician Primary Care Physician

Phone/Address: Phone/Address:

Primary Pharmacy Phone/Address:

Patient's Legal Name:

S.S # Last Date of Birth First Middle Age: Sex M F

Street Address City: State: Zip

Home Phone ( ) Cellular Phone ( )

Mailing address (if different from above)

Employer/Occupation: Work Phone ( )

Marital Status: S M W D Spouse's name

Spouse's employer Work Phone ( )

Nearest friend or relative (not living with you)

Phone ( ) Relationship

**GUARANTOR INFORMATION (Person responsible for payment)**

Primary Insurance Group # Subscriber #

Subscriber's name: Relationship Phone ( )

Subscriber's S.S.# Date of Birth Sex: M F Marital Status S M W D

Employer/: Work Phone: ( )

Employer address:

Secondary Insurance Group # Subscriber #

Subscriber's name: Relationship Phone ( )

Subscriber's S.S.# Date of Birth Sex: M F Marital Status S M W D

Employer: Work Phone: ( )

Employer address:

Assignment of Benefits: I hereby assign all benefits for services by Spokane Urology and include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, and I ask that Spokane Urology or Dr: furnish all requested medical information of the person or entity named above. I understand that my records may contain information regarding the diagnosis of treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. (Statement required by law) This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I understand that I am financially responsible to the provider for charges not covered by my benefit plan.

Signed Date

Patient/other legally responsible person (signature and relationship)