COMPREHENSIVE
UROLOGIC CARE

PATIENT INFORMATION (Please Print) Date: _____

Patient First _____ Middle Initial _____ Last_____

Birthdate: ___/____/_____ Patient Financially Responsible ____Yes ____No Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: (_____) _____ (Circle One) Cell Home Work Other

Secondary Phone: (_____) _____ (Circle One) Cell Home Work Other

Email Address: _____Prefer Contact By: (Circle One) Phone Email
Text (Phone Carrier)_____

____Male ____Female Social Security Number: _____-_____-_____

Referring Physician: _____Primary Care Physician: _____

Employer: _____City, State, Zip Code: _____

PRIMARY INSURANCE PLAN NAME: _____

Please indicate: _____PPO ____ HMO ____ Medicare ____ Self Insured

Insured's ID Number: _____ Group Policy Number: _____

Insured Name If other than Patient: _____ Birthdate: ___/____/_____

Relationship to Patient: _____

SECONDARY INSURANCE PLAN NAME: _____

Please indicate: _____PPO ____ HMO ____ Medicare ____ Self Insured

Insured's ID Number: _____ Group Policy Number: _____

Insured Name If other than Patient: _____ Birthdate: ___/____/_____

Relationship to Patient: _____

IN CASE OF EMERGENCY OR INABILITY TO REACH PATIENT PLEASE CALL:

Name: _____Phone:( ) _____ Relationship:_____

Would you like this person to coordinate all care, including scheduling for you? _____Yes_____No

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Patient First _____ Last_____Date of Birth: __/___/_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have been made aware of CUC's Notice of Privacy Practices, which is posted on their website, as well as available upon request in their office.

____ I Place No Restrictions

____ Restrict all of my Protected Health Information, except for the following individuals:

Name: _____Relationship:_____Date of Birth: _____

Name: _____Relationship:_____Date of Birth: _____

NOTICE OF INSURANCE RELEASE OF INFORMATION AND AUTHORIZATION FOR PAYMENT

- I authorize the release of any medical or other information acquired in the course of my examination or treatment to insurance carriers.
- I authorize payment of medical benefits direct to Comprehensive Urologic Care for medical/surgical services rendered to me or my dependents.
- I understand that it is my responsibility to satisfy any payment obligations required by my insurance carrier at the time of service and am financially responsible for any services not covered by my insurance carrier.

ACKNOWLEDGEMENT OF OFFICE POLICIES

I acknowledge that I have been made aware of CUC's Office Policies, which is posted on their website, as well as available upon request in their office.

Signature of Patient or Legal Guardian

X_____ Date:_____