

Today's Date \_\_\_\_\_

Marital Status:(circle one) Single Married Legally Separated Widowed Divorced  
Student:(circle one) Full-time Part-time Not student  
Name: \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle  
Sex:  Male  Female Date Of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Employment Status: (circle one) Full time Part-time Retired Disabled Not Employed  
Spouse's Name: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Referring Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Physician Address: \_\_\_\_\_  
Would your religious faith in any way interfere with your medical care? \_\_\_\_\_

**Insurance Information**

**Primary Health Insurance Company:** \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Date of Birth of Subscriber: \_\_\_\_\_  
Insurance address: \_\_\_\_\_  
Insurance telephone number: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group or Plan #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Out Patient Coverage?  Yes  No  
**Secondary Health Insurance Company:** \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Date of birth of subscriber: \_\_\_\_\_  
Insur. address: \_\_\_\_\_  
Insur. telephone number: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group or Plan #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Guarantor Information (Responsible Party)**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event of an emergency, contact \_\_\_\_\_ At ( ) \_\_\_\_\_  
Contact #2 \_\_\_\_\_ At ( ) \_\_\_\_\_  
Name and Phone of Relative Not Living With Patient: \_\_\_\_\_

**GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO TREAT**

I authorize the release of any medical or other information necessary to process this claim to my referring physician/family physician/insurance company including Medicare, to North Carolina Urological Associates. The insured or authorized person's signature gives permission for the above party to receive this payment or release medical information. I agree to pay for services when it is a non-covered benefit or referral from my primary physician was not obtained at the time of my visit. I have reviewed this information and to the best of my knowledge it is complete and accurate.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_