

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: _____