

NORTHWEST SUBURBAN UROLOGY ASSOCIATES, S.C
PATIENT INFORMATION

PATIENT DATA (MUST BE FILLED OUT COMPLETELY)

NAME _____ **GENDER:** MALE FEMALE
 (First) (Middle) (Last)

SOCIAL SECURITY NO. _____ **MARITAL STATUS:** DIVORCED MARRIED SEPARATED SINGLE WIDOWED

DOB: _____ AGE _____ RACE _____ ETHNICITY _____ LANGUAGE _____

HOME STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ CELL PHONE (____) _____

WORK PHONE (____) _____ EMAIL _____

CONSENT FOR VERBAL RELEASE OF INFORMATION:

PREFERRED CONTACT METHOD: HOME PHONE CELL PHONE TEXT MESSAGE WORK PHONE EMAIL

PREFERRED APPOINTMENT REMINDER METHOD: HOME PHONE CELL PHONE TEXT MESSAGE WORK PHONE EMAIL

MAY WE LEAVE DETAILED MESSAGES ON YOUR VOICEMAIL?* HOME PHONE CELL PHONE WORK PHONE NO

MAY WE LEAVE LAB AND/OR TEST RESULTS ON YOUR VOICEMAIL?* HOME PHONE CELL PHONE WORK PHONE NO

*Answering machine /voicemail must have an identifying message to confirm these are your numbers.
 For example: "You have reached John Doe."

EMERGENCY CONTACT _____ **RELATIONSHIP:** _____

ADDRESS _____ **PHONE** (____) _____
 (Street) (City) (State/Zip)

List any persons with whom we may share details about your healthcare. Indicate below whether this may include sensitive health information (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatment and/or diagnosis, treatment and/or referral and genetic testing:

NAME	RELATIONSHIP	RELEASE SHI?
		YES NO
		YES NO
		YES NO

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature _____ **Date** _____

If you are not the patient please specify your relationship to the patient: _____

NORTHWEST SUBURBAN UROLOGY ASSOCIATES, S.C
PATIENT INFORMATION

PATIENT NAME _____ **DATE OF BIRTH:** _____

YOUR PRIMARY CARE PHYSICIAN _____
(First) (Last) (City) (Phone)

PHYSICIAN WHO REFERRED YOU TO OUR OFFICE _____
(First) (Last) (City) (Phone)

PHARMACY INFO: _____
(Name) (Street/Intersection) (City) (Phone)

ACCOUNT GUARANTOR NAME: _____ **DATE OF BIRTH:** _____

RELATIONSHIP TO PATIENT: _____ **SOCIAL SECURITY NO.:** _____

HOME STREET ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE (____) _____ **CELL PHONE** (____) _____

WORK PHONE (____) _____

EMPLOYER _____ **PHONE** (____) _____

INSURANCE DATA (MUST BE FILLED OUT COMPLETELY)

PRIMARY INSURANCE CO. _____ **GROUP/POLICY NO.** _____

IS THIS AN HMO, PPO, OR POS? ___ YES ___ NO DO YOU REQUIRE A REFERRAL? ___ YES ___ NO

INSURED'S NAME _____ **INSURED'S DOB:** _____

INSURED'S I.D. NO. _____ **EMPLOYER** _____

SECONDARY INSURANCE CO. _____ **GROUP/POLICY NO.** _____

IS THIS AN HMO, PPO, OR POS? ___ YES ___ NO DO YOU REQUIRE A REFERRAL? ___ YES ___ NO

INSURED'S NAME _____ **INSURED'S DOB:** _____

INSURED'S I.D. NO. _____ **EMPLOYER** _____

I authorize the release of medical information necessary to evaluate my claim for benefits for services rendered. I also authorize direct payment to Northwest Suburban Urology Associates, S.C. for any charges I have not paid. I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges for professional services rendered to me, including those deemed non-reimbursable or unnecessary by Medicare or other insurance carriers. It is my responsibility to notify this office if pre-certification is required by my insurance carrier for any surgical procedures. I have read and understand the attached statement of financial policy which pertains to my insurance status.

Signature _____ **Date** _____

If you are not the patient please specify your relationship to the patient: _____