

Scottsdale Center for Urology

Patient Information Record

PATIENT NAME			<u>SEX</u>	SINGLE	<u>DATE OF BIRTH</u>	SS #
MALE	MARRIED	MONTH/ DAY/ YR				
FEMALE	WIDOWED	___/___/___				
LAST NAME	FIRST NAME	MI				
MAILING ADDRESS - STREET/PO BOX, CITY, STATE AND ZIPCODE				CELL PHONE # ()		
				HOME PHONE # ()		
OCCUPATION		EMPLOYERS NAME		BUSINESS PHONE		
				()		
PRIMARY CARE DOCTOR		PRIMARY CARE DOCTOR'S ADDRESS		PRIMARY DOCTOR'S PHONE NUMBER		
				()		
PHARMACY NAME		PHARMACY ADDRESS		PHARM PHONE #		
				()		

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES _____ NO _____ MAY WE DISCUSS YOUR CARE/ACCOUNT WITH YOUR SPOUSE? YES _____ NO _____ SPOUSES NAME _____	WHO DO WE CONTACT IN CASE OF AN EMERGENCY? NAME: _____ PHONE #: _____
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PRIMARY INSURANCE COMPANY	POLICY ID # OR MEMBER #	GROUP #
POLICY HOLDER'S NAME	RELATIONSHIP TO PATIENT	BIRTHDATE OF POLICY HOLDER
POLICY HOLDER'S ADDRESS (IF DIFFERENT THAN PATIENTS)		PHONE NUMBER
POLICY HOLDER'S EMPLOYER		WORK NUMBER

SECONDARY INSURANCE COMPANY	POLICY ID # OR MEMBER #	GROUP #
POLICY HOLDER'S NAME	RELATIONSHIP TO PATIENT	BIRTHDATE OF POLICY HOLDER
POLICY HOLDER'S ADDRESS (IF DIFFERENT THAN PATIENTS)		PHONE NUMBER
POLICY HOLDER'S EMPLOYER		WORK NUMBER

Your insurance company requires that you complete this form yearly.

Signature _____ **Date:** _____

Signature _____ **Date:** _____

Signature _____ **Date:** _____