

Scottsdale Center for Urology

Patient Information Record

PATIENT NAME LAST NAME FIRST NAME MI			SEX MALE FEMALE	SINGLE ___ MARRIED ___ WIDOWED ___	BIRTH DATE MO/ DAY/ YR _/_/___	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY, STATE AND ZIPCODE			HOME PHONE ()	
					CELL PHONE ()	
OCCUPATION		EMPLOYERS NAME		BUSINESS PHONE ()		
PRIMARY DOCTOR		PRIMARY DOCTOR'S ADDRESS		PRIMARY DOCTOR'S PHONE NUMBER ()		

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES _____ NO _____		WHO DO WE CONTACT IN CASE OF AN EMERGENCY? NAME: _____	
MAY WE DISCUSS YOUR CARE/ACCOUNT WITH YOUR SPOUSE? YES _____ NO _____ SPOUSES NAME _____		PHONE #: _____	
PARENT NAME (IF PATIENT IS A MINOR)	RELATIONSHIP TO PATIENT	ADDRESS (IF DIFFERENT FROM ABOVE)	PHONE

PRIMARY INSURANCE PLAN		POLICY ID # OR MEMBER #		GROUP #	
POLICY HOLDER		RELATIONSHIP TO PATIENT		BIRTHDATE OF POLICY HOLDER	
POLICY HOLDER'S ADDRESS, CITY, STATE AND ZIPCODE				PHONE NUMBER	
POLICY HOLDER'S EMPLOYER				WORK NUMBER	
SECONDARY INSURANCE PLAN		POLICY ID # OR MEMBER #		GROUP #	
POLICY HOLDER		RELATIONSHIP TO PATIENT		BIRTHDATE OF POLICY HOLDER	
POLICY HOLDER'S ADDRESS, CITY, STATE AND ZIPCODE				PHONE NUMBER	
POLICY HOLDER'S EMPLOYER				WORK NUMBER	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS... I authorize release of any and all medical records necessary for my medical care and/or processing of my medical claims by voice, fax, electronic or written means. I authorize payment of medical benefits to my providers Erik E. Alexander, MD., Micheal F. Darson, M.D., Bernard M. Gburek, MD., and Robert H. Shapiro, MD for services rendered now and in the future, without obtaining my signature on each claim submitted. This signature will bind me as though I personally signed each claim. I also understand that I am financially responsible for all charges whether or not paid buy insurance. Furthermore, I understand that I am responsible for all co-pays, co-insurances, deductibles, and non-covered services. In the event I default on prompt payment, I will be liable for the full remaining charges along with collection and/or legal fees of unpaid balances if my account is referred to a collection agency.

Responsible Party Signature _____ Date: _____