

Scottsdale Center for Urology

Patient Information Record

PATIENT NAME			SEX	SINGLE ___	BIRTH DATE MO/ DAY/ YR	SOCIAL SECURITY NUMBER
			MALE	MARRIED ___	___/___/___	
LAST NAME FIRST NAME MI			FEMALE	WIDOWED ___		
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 ()		
PHARMACY NAME		PHARMACY ADDRESS		PHARM PHONE - PHARM FAX -		

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 #: _____

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 by 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.

Your insurance company requires that you complete this form yearly.

Responsible Party Signature _____ Date: _____