

## Urologic Patient Information Form

### Patient Information

Med Rec # \_\_\_\_\_

Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address \_\_\_\_\_

Physical Address (if different from mailing) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex: M / F Marital Status: S / M / D / W

Employer \_\_\_\_\_ City \_\_\_\_\_

Spouse \_\_\_\_\_ Spouse Soc Sec # \_\_\_\_\_

If a physician or other medical provider referred you, who referred you \_\_\_\_\_

Race (circle one): American Indian or Alaskan Native / Asian / Black or African American /  
Native Hawaiian or other Pacific Islander / White

Ethnicity (circle one): Hispanic / Non Hispanic

Preferred Language (circle one if preferred): English / Spanish / Other \_\_\_\_\_

Email address: \_\_\_\_\_

Preferred Method of contact (circle one): Phone – Home or Cell / Mail / Email

Preferred Pharmacy/Location \_\_\_\_\_

### Parent or other Responsible Party if other than patient

Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex: M / F Marital Status: S / M / D / W

Employer \_\_\_\_\_ City \_\_\_\_\_

### Insured Information if Insured is Not Patient nor Responsible Party

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_

Insured's Phone Number \_\_\_\_\_ Employer \_\_\_\_\_

### Notice of Privacy Practices

I acknowledge I have been offered a copy of Urologic's Notice of Privacy Practices:

Signature \_\_\_\_\_

### Release of Medical Information

I authorize the staff at Urologic to discuss my medical information with the following persons. This authorization shall remain in effect until such time as it is withdrawn by me in writing.

\_\_\_\_\_  
Relationship \_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_  
Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### Emergency Contact Information (must be someone listed above)

Name \_\_\_\_\_ Phone number(s) \_\_\_\_\_

### Telephone Consent

I understand the Clinic or its agents may use prerecorded/artificial voice messages and/or auto dialing devices to remind me about appointments or notify be of other information and I expressly consent to the Clinic or its agents use of any number associated with my account, including wireless numbers, including contact done by prerecorded/artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account.

Signature \_\_\_\_\_ Date \_\_\_\_\_