NORTH CAROLINA UROLOGICAL ASSOCIATES
Patient Information

Account #_____

Doctor_____

Today's Date_____

Marital Status:(circle one) Single Married Legally Separated Widowed Divorced

Student:(circle one) Full-time Part-time Not student

Name: _____Age_____

Last First Middle

Sex: ___Male___Female Date Of Birth _____ S.S.# _____-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____

Employer's Address:_____

Employment Status: (circle one) Full time Part-time Retired Disabled Not Employed

Spouse's Name: _____ Spouse's Work Phone: _____

Spouse's Employer: _____ S.S.# _____-_____-_____ Date Of Birth: _____

Referring Physician Name:_____ Phone:_____

Referring Physician Address:_____

Would your religious faith in any way interfere with your medical care? _____

Insurance Information

Primary Health Insurance Company: _____

Subscriber:_____Date of Birth of Subscriber:_____

Insurance address:_____

Insurance telephone number:_____

ID Number: _____ Group or Plan #: _____

Relationship to Patient: _____

Effective Date: _____ Out Patient Coverage? __Yes__No

Secondary Health Insurance Company:_____

Subscriber: _____ Date of birth of subscriber:_____

Insur. address: _____

Insur. telephone number: _____

ID Number: _____ Group or Plan #: _____

Relationship to Patient: _____ Effective Date: _____

Guarantor Information (Responsible Party)

Name: _____

Date of Birth: _____ S.S.#: _____-_____-_____

Relationship to Patient: _____ Home Phone: _____

Address:_____

Employer:_____

Employer's Address: _____ Phone: _____

In the event of an emergency, contact _____ At ( ) _____

Contact #2 _____At ( ) _____

Name and Phone of Relative Not Living With Patient: _____

GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO TREAT

I authorize the release of any medical or other information necessary to process this claim to my referring physician/family physician/insurance company including Medicare, to North Carolina Urological Associates. The insured or authorized person's signature gives permission for the above party to receive this payment or release medical information. I agree to pay for services when it is a non-covered benefit or referral from my primary physician was not obtained at the time of my visit. I have reviewd this information and to the best of my knowledge it is complete and accurate.

Date: _____ Signature: _____