



Patient Information

PATIENT INFORMATION

NAME _____ BIRTH DATE _____
LAST FIRST MI

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____ SOCIAL SECURITY # _____ / _____ / _____

CITY _____ STATE _____ ZIP _____ HOME PHONE (_____)
 OK TO CONTACT

EMAIL ADDRESS _____ CELL PHONE (_____)
 OK TO CONTACT OK TO CONTACT

MARITAL STATUS (CHECK ONE) SINGLE MARRIED DIVORCED SEPARATED SEX M F

WORK INFORMATION

EMPLOYER'S NAME _____ WORK PHONE (_____)

EMPLOYER'S ADDRESS _____ OCCUPATION _____

REFERRING / PRIMARY CARE PHYSICIAN INFORMATION

PRIMARY PHYSICIAN NAME _____ PHONE NUMBER (_____)

AND/OR REFERRING PHYSICIAN NAME _____

PRIMARY INSURANCE

INSURANCE COMPANY _____ PHONE NUMBER (_____)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER NAME _____ DOB _____ I.D. NUMBER _____

SUBSCRIBER'S EMPLOYER NAME _____ GROUP NUMBER _____ CO PAY AMT. _____

SECONDARY INSURANCE

INSURANCE COMPANY _____ PHONE NUMBER (_____)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER NAME _____ DOB _____ I.D. NUMBER _____

SUBSCRIBER'S EMPLOYER NAME _____ GROUP NUMBER _____ CO PAY AMT. _____

EMERGENCY INFORMATION

RELATIVE TO CONTACT (OTHER THAN SPOUSE) _____ PHONE NUMBER (_____)

OTHER PERSON TO CONTACT (NOT RELATIVE) _____ PHONE NUMBER (_____)

HOW DID YOU HEAR OF OUR OFFICE? PHYSICIAN FRIEND SELF PHONE BOOK PSC WEBSITE VASECTOMY.COM

OTHER _____

I authorize examination and treatment for myself or any family member I bring you for care unless that person makes independent arrangements for paying you.

I understand that I am responsible for any and all bills incurred by myself or such family members for whom I am responsible as stated above. I understand that I may be billed for such care even if it is covered by an insurance company unless Puyallup Surgical Consultants (a division of Urologic Consultants, PLLC) has agreed with the health care carrier not to ask me for payment. Even in the latter case, I may still be responsible for some charges, for example, co-payments and deductibles.

I understand that in the event my account becomes delinquent, I and the account will be turned over for collection.

I further understand that in the event my account is turned over for collection, I will be terminated as a patient in the manner set out in Puyallup Surgical Consultants, (a division of Urologic Consultants, PLLC) then current policy. In that case, it will be my responsibility to seek and arrange care by another physician. I agree to undertake that responsibility.

I hereby authorize assignment of any and all insurance benefits, if any, applicable to care I receive from Puyallup Surgical Consultants, (a division of Urologic Consultants, PLLC). I authorize release of health care and patient information to any insurance carrier I identify to Puyallup Surgical Consultants, (a division of Urologic Consultants, PLLC).

Medicare Authorization: If applicable, I request that payment under the medical insurance program be made to Puyallup Surgical Consultants (a division of Urologic Consultants, PLLC) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Medicare Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

I acknowledge that I have had an opportunity to speak with someone at Puyallup Surgical Consultants, (a division of Urologic Consultants, PLLC) about any questions or concerns regarding these matters before signing it.

Signature

Date

Relationship

Initial