



Date of Birth \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Patient's Name: 1st \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  
Patient's Sex: \_\_\_\_\_ Patient's Social Security #: \_\_\_\_\_ Marital Status S M W D  
(circle)  
Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Employer: \_\_\_\_\_  
If patient is minor, person responsible for account: Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance Information**

**PRIMARY INSURANCE:**

Insurance Co. Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
Subscriber Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

**SECONDARY INSURANCE:**

Insurance Co. Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
Subscriber Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

**PRIMARY PHYSICIAN:** \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Is your visit work related? Y N Date Accident Occurred: \_\_\_\_\_  
Is your visit auto related? Y N Date Accident Occurred: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**LIST ALLERGIES:**

**CURRENT MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, hereby authorize the release of any surgical and/or medical information necessary for the processing of insurance benefits payable to myself or Urology Associates of Battle Creek, P.C., including medical and/or major medical benefits. I am financially responsible to Urology Associates of Battle Creek, P.C. for services not covered by their assignment. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. In Medicare/other insurance company assigned cases Urology Associates of Battle Creek, P.C. agrees to accept the allowed amount determined by Medicare/other insurance company and I will be responsible for all deductible's, co-insurance and non-covered services.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

I, authorize Urology Associates of Battle Creek, P.C. to provide a billing agency, with whatever demographic, insurance and clinical information is reasonable and necessary to obtain payment from both the insurance carrier and the responsible party.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

If no insurance or lack of complete insurance information, I am responsible for the total charge **ON THE DATE OF SERVICE.**

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to Urology Associates of Battle Creek, P.C. for any services furnished me by said provider. I authorize any holder of surgical and/or medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date