Patient Information

First Name _____MI_____Last _____

Date of Birth _____/_____/_____ Age_____ Social Security # _____-_____-_____ Marital Status: S W M D

Preferred name if different than above _____

Race (optional, this information is requested on some of our lab requisitions)_____

Mailing address _____Apt# _____

City _____State _____ Zip _____

Physical Address _____ Apt# _____

City _____State _____ Zip _____

Primary phone (___)_____ Secondary phone (____)_____3rd phone (___)_____

Employer _____ Occupation _____

Primary care doctor _____Referred by _____

Spouse Information

First Name _____ MI _____ Last _____

Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Employer _____ Occupation _____

Primary phone (___)_____Secondary phone (____)_____

Responsible Party for Insurance (if different than above)

First Name _____MI_____ Last _____

Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Employer _____ Occupation _____

Primary phone (___)_____ Secondary phone (____)_____

Emergency Contact (name of a friend or relative not living with you who can be reached in case of an emergency)

Relationship to Patient _____

First Name _____ Last _____ Phone# (___)_____

Address _____City _____ State ____ Zip _____

Please indicate by circling applicable insurance coverage: COPY OF INSURANCE CARD REQUIRED

INSURANCE: YES NO 2ND INSURANCE: YES NO PRIVATE PAY: YES NO

INS. Name: _____ INS. Name: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT/CONTRACT

I hereby authorize Pacific Northwest Urology Specialists to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the provider Pacific Northwest Urology Specialists. I hereby agree to full responsibility for all expenses incurred by minor child or myself. I understand that a re-billing fee/finance charge complying with Washington State Law will be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. **Medicare: I understand that my provider is contracted with Medicare and I agree to pay the physician for services Medicare may determine to be "non-covered" or "medically unnecessary". I understand that my provider will obtain my authorization prior to performing services, which have limited coverage under Medicare rule.

Signature _____ Date _____/_____/_____