Colorado UROLOGY®

PATIENT INFORMATION – Patient #

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:**
City:	**E-Mail Address:**
State: Zip:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Referring Physician:	**Internist/Family Physician:**
Your Pharmacy:	**Pharmacy Phone:**
Employment Status: (One): Retired Full Time Part Time Military Self None	
Marital Status: (One): Married Divorced Single Separated Widowed	
Circle how you heard about us: (One) Yellow Pages Newspaper Physician Family/Friend Radio Internet Insurance Company Community Program Mailing Other:_____	
Race: American Indian or Alaska Native / Asian / Black or African American/ Native Hawaiian / White / Refused to Report-Unreported / Other Pacific Islander / More than one race	
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Refused to Report	
Preferred Language (Please Print):	
Pref. Notification Method for Preventive Health Reminders: Postal Mail / Phone / Web Message	
Are you a Nursing Home or Assisted Living resident (One)? YES / NO	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**
Co-Pay Amount:	**Co-Pay Amount:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, COLORADO UROLOGY ASSOCIATES when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, COLORADO UROLOGY ASSOCIATES to release any information necessary for my course of treatment.

_____ _____

Signature (patient or parent if minor) Date