# RIVERSIDE UROLOGY, INC

… Committed to excellence in patient care

## PATIENT INFORMATION

First Name __________________________ M.I. ______ Last Name ____________________________________

Address ________________________________________ City _________________ State ____ Zip _________

Cell Phone (_____)__________________ Email address_____________________________________________

Home Phone (_____)___________________________ Work Phone (_____)___________________________

Birth Date _________________ Age _____ SS# _______________________ Sex: Male _____ Female ______

Marital Status: S- M- D- W Spouse/ Significant Other's Name ____________________________________

Emergency Contact: ___________________ Relationship _______ Phone Number (____) _________________

**How did you hear about us?**

Patient: Name ____________________________________________________________________

Referring Physician: Name ____________________________________________________________________

Urgent Care: Name ____________________________________________________________________

Radio Station: Name ___________________ Website ______ Other ____________________________

**Who is your Primary Care Physician?** Name ____________________________________________________

Address _______________________ City _______________ State ____ Zip ______ Phone _______________

## INSURANCE INFORMATION

Is the insurance in your name? Yes ____ No ____ If NOT, insured party's name __________________________

SS# ________________________ Birth date _______________ Relationship ____________________________

**SELF-PAY** I understand that FULL payment is due at time of services. Initial __________ Date ____________

## INSURANCE AUTHORIZATION

I understand that my signature authorizes Riverside Urology, Inc. to process all insurance claims for services provided for me or any minor dependent of mine. I authorize the release of any information necessary to process a claim. I understand that payment for medical services is my responsibility even if I am covered under an insurance plan. If payment is not received after 30 days from a covered insurance plan, I agree to make full payment within 90 days from date of service. If I have Medicare coverage, I agree to pay my portion of the responsibility. I have read this authorization and I understand and agree with its contents.

Signature _______________________________________________________ Date _______________________

Signature _______________________________________________________ Date _______________________

**ALLERGIES** ____________________________________________________________________________