

# UROLOGY ASSOCIATES OF WILLIAMSON COUNTY

Date: \_\_\_\_\_ Referred by: Dr. \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

## PATIENT INFORMATION

## DATE OF BIRTH \_\_\_\_\_

## AGE: \_\_\_\_\_

Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ Apt.# \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Marital Stats: Married  Single  Widowed  Divorced  Employer \_\_\_\_\_ Years \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Employers Address \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Phone Number \_\_\_\_\_ Employer's Phone Number \_\_\_\_\_

## SPOUSAL INFORMATION

Name \_\_\_\_\_ Employer \_\_\_\_\_ Years \_\_\_\_\_  
Address \_\_\_\_\_ Employers Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer's Phone Number \_\_\_\_\_

## IF THE PATIENT IS A MINOR OR STUDENT

Father's Name _____	Mother's Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Father's Occupation _____	Mother's Occupation _____
Father's Employer _____	Mother's Employer _____
PHONE	PHONE
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
_____	_____
_____	_____

## INSURANCE INFORMATION

### MEDICARE

Number \_\_\_\_\_  
Hospital Effective Date \_\_\_\_\_  
Medical Effective Date \_\_\_\_\_

### MEDICAID

Number \_\_\_\_\_  
County \_\_\_\_\_

### BLUE SHIELD

I.D. Number \_\_\_\_\_  
Code \_\_\_\_\_

### BLUE CROSS

Certificate Number \_\_\_\_\_  
Group Number \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_

### ACTIVE CHAMPUS

### RETIRED CHAMPUS

### GROUP OR PRIVATE INSURANCE

Company Name \_\_\_\_\_  
Company Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Employer (if group insurance) \_\_\_\_\_

### INSURANCE PREFERRED (Please Complete)

LABORATORY: \_\_\_\_\_

RADIOLOGY FACILITY: \_\_\_\_\_

**In order to control billing costs, we request that office visits be paid for at the time service is rendered. We would rather control billing costs than raise our fees.**