BAY AREA UROLOGY PATIENT INFORMATION FORM

HOSPITAL CONSENT SIGNED____
DATE_____
Acct. #_____
DOES PATIENT SMOKE?_____

PLEASE INCLUDE AREA CODES Your Pharmacy_____ Phone(____) _____

UPDATE:_____ _____
_____ _____
_____ _____
_____ _____

Referring Physician_____

If referred by patient or other person, please name_____

Other referral (Yellow pages, etc.)_____

PATIENT NAME AND ADDRESS:

SEX AGE BIRTHDATE MARITAL STATUS

_____ ____ ____ _____ _____
Last name First name (M. I.)

_____ _____
Address Apt. # City State Zip Code

Mailing Address (if different)_____

Phone #'s: HOME( )_____ WORK ( )_____ CELL ( ) _____

Patient's Employer:_____ Patient SS#_____

Spouse's Name:_____ Spouse Work# ( )_____

Spouse's Employer:_____ Spouse's SS#_____

GUARANTOR (Person responsible for payment of charges) Relation to patient_____

Name:_____ Phone#:HOME ( )_____OFFICE ( )_____

Address:_____

Guarantor's SS#:_____ Guarantor's DOB_____

Guarantor's Driver's License (State+#)_____ Guarantor's Employer_____

If patient is minor or non-responsible, please give telephone numbers where parents or responsible party can be reached:

Mother: Day( )_____Evening( )_____Father: Day( )_____Evening( )_____

Person to notify in emergency (Relative or friend not living at patient's address):

Name:_____ Phone:( )_____ Relationship_____

PLEASE COMPLETE THE FOLLOWING SECTIONS (WHERE APPLICABLE)

PRIMARY MEDICAL INSURANCE (IF MEDICARE, MEDICAID OR WORKMAN'S COMPENSATION, SEE BELOW.

Name of Insurance Company_____ (Check One) Group_____ Private_____

Insured Person (employee)_____ Employer_____

Policy or Group #_____ Certificate or ID #_____ Phone# ( )_____

Address for filing claims:_____

SECONDARY MEDICAL INSURANCE:

Name of Insurance Company_____ (Check One) Group_____ Private_____

Insured Person (employee)_____ Employer_____

Policy or Group #_____ Certificate or ID #_____ Phone# ( )_____

Address for filing claims:_____

IF PATIENT IS COVERED BY MEDICARE, PLEASE COMPLETE BELOW:

CHECK ONE: REGULAR SOCIAL SECURITY MEDICARE_____ OR RAILROAD RETIREMENT MEDICARE_____

MEDICARE # (Include all letters)_____

IF PATIENT IS COVERED BY MEDICAID, PLEASE SEE RECEPTIONIST OR OFFICE MANAGER
MEDICAID RECIPENT NUMBER:_____

IF PATIENT IS SEEING THE DOCTOR BECAUSE OF AN INJURY WHICH OCCURRED ON THE JOB, PLEASE ADVISE THE RECEPTIONIST BEFORE SEEING THE DOCTOR.

MEDICARE PATIENTS: WE ARE A PARTICIPATING PROVIDER WITH MEDICARE, WHICH MEANS THAT WE WILL ACCEPT ASSIGNMENT ON MEDICARE CLAIMS; THEREFORE, ALL MEDICARE PAYMENT ARE MADE TO THE PROVIDER, AND THE INSURED IS RESPONSIBLE FOR PAYMENT OF HIS/HER ANNUAL DEDUCTIBLE AND HIS/HER TWENTY (20) PERCENT CO-SHARE OF ALL ALLOWED CHARGES. DR. WAGNER HAS A VESTED INTEREST IN HOUSTON PHYSICIANS' HOSPITAL. IF NO VERIFIABLE SUPPLEMENT INSURANCE INFORMATION IS SUPPLIED, THE PATIENT WILL BE RESPONSIBLE FOR THESE AMOUNTS AT THE TIME OF SERVICE.

OTHER PATIENTS: IF YOU ARE ON A MANAGED INSURANCE PLAN (HMO, PPO OR IPA), BE SURE TO ADVISE THE RECEPTIONIST AT ONCE AND PLEASE COMPLETE THE INFORMATION SHEET INCLUDED WITH THIS FORM PRIOR TO SEEING THE PHYSICIAN.

PLEASE PRESENT YOUR DRIVER'S LICENSE, INSURANCE IDENTIFICATION CARD AND/OR YOUR MEDICARE CARD, OR YOUR CURRENT MEDICAID CERTIFICATE TO THE RECEPTIONIST SO THAT SHE CAN MAKE PHOTOCOPIES FOR YOUR CHART. IF ANY OF THE INFORMATION YOU PROVIDE ON THIS FORM SHOULD CHANGE DURING THE COURSE OF YOU CARE, BE SURE TO ADVISE THE RECEPTIONIST AT ONCE.

PATIENT NAME_____SIGNATURE_____