

PATIENT INFORMATION

PATIENT NAME _____ M F DOB _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ SS# _____

RESPONSIBLE PARTY _____

MARITAL STATUS OF PARENTS Married Single Divorced Widowed

MOTHER'S NAME _____ DOB _____
ADDRESS IF DIFFERENT FROM ABOVE _____
HOME PHONE _____ CELL _____ SS# _____
EMPLOYER _____ WORK PHONE _____
OCCUPATION _____

FATHER'S NAME _____ DOB _____
ADDRESS IF DIFFERENT FROM ABOVE _____
HOME PHONE _____ CELL _____ SS# _____
EMPLOYER _____ WORK PHONE _____
OCCUPATION _____

CHILDS PRIMARY CARE PHYSICIAN _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
FAX _____

PRIMARY INSURANCE _____ ID# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PRIMARY INSURED _____ DOB _____ GROUP# _____
EFFECTIVE DATE _____ PHONE _____

SECONDARY INSURANCE _____ ID# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PRIMARY INSURED _____ DOB _____ GROUP# _____
EFFECTIVE DATE _____ PHONE _____

EMERGENCY CONTACT – Please list someone other than parent's of child.

ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____
RELATIONSHIP TO THE PATIENT _____

PLEASE READ AND SIGN THE FOLLOWING:

I hereby authorize Rocky Mountain Pediatric Urology, P.C. to furnish information to insurance companies concerning my or my dependent's illness and treatment and I hereby assign Rocky Mountain Pediatric Urology, all payments for medical services rendered to my dependents or myself. I understand and agree that I am responsible for any billed amount not covered by my insurance. I understand that **COPAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE.** I agree to pay a \$10.00 processing fee for any co-payments not made at that time. I also agree that in the event my account becomes delinquent and is assigned for collection that I will be responsible for all costs of collections, attorney fees and court costs. I understand that if my insurance company requires a referral for specialty services, I must obtain this referral from my primary care physician. If I have not obtained a referral prior to the visit with Rocky Mountain Pediatric Urology, I can postpone the appointment until this referral is obtained, otherwise I agree to accept full financial responsibility for any direct ancillary (laboratory or radiology) charges related to services rendered.

DATE _____ PARENT SIGNATURE _____