WELCOME TO UROLOGY CARE CENTER, S.C.

SS# ____/____/_____ LAST____________________FIRST__________________MI___________

ADDRESS___________________________APT____ CITY_____________STATE_____ZIP_______

DOB __/__/___MARITAL STATUS- S M D W SEX: M F E-MAIL: _________________________

HOME PHONE _____________________WK________________CELL______________________

EMPLOYER___________________________OCCUPATION_______________________________

SPOUSE/PARENT______________________________PHONE____________________________

PCP OR REFERRING PHYSICIAN (CIRCLE ONE)

NAME________________________________PHONE___________________________________

ADDRESS______________________________CITY_______________STATE______ZIP________

EMERGENCY CONTACT

NAME__________________________RELATION___________________PHONE______________

ADDRESS____________________________CITY______________STATE_____ZIP____________

PHARMACY **DRUG ALLERGIES**_____________________

NAME____________________________CITY_________________PHONE__________________

INSURANCE INFORMATION – HMO POS PPO MC (CIRCLE ONE)

NAME_________________________ID#_____________________GRP_____________________

POLICYHOLDER_____________________SS#___________________DOB___________________

ADDRESS_____________________________PHONE___________________________________

SECONDARY INS. INFORMATION – HMO POS PPO MC (CIRCLE ONE)

NAME________________________ID#___________________GRP_______________________

POLICYHOLDER_________________________SS#_____________________DOB_____________

ADDRESS______________________________PHONE__________________________________

I AGREE THAT BENEFITS BE PAID DIRECTLY TO UROLOGY CARE CENTER, S.C. I AGREE TO PAY ALL COLLECTION COSTS INCURRED IN AN AMOUNT NOT TO EXCEED 50% OF THE UNPAID BALANCE SHOULD ANY UNPAID BALANCE BE REFERRED TO A COLLECTION AGENCY. IN ADDITION SHOULD ANY UNPAID BALANCE BE REFERRED TO AN ATTORNEY FOR LITIGATION, ALL REASONABLE ATTORNEY FEES AND COURT COSTS SHALL BE PAID FOR BY THE UNDERSIGNED AS ALLOWED BY THE COURT. **I ACKNOWLEDGE THERE WILL BE A $25.00 CHARGE FOR ALL MISSED OFFICE APPOINTMENTS AND A $50.00 CHARGE FOR ALL MISSED SURGICAL APPOINTMENT WITHOUT A 24 HOUR NOTICE.**

SIGNATURE____DATE_____________________