DuPage Urology Associates, LTD

Tel: 630.369.1572 Fax: 630.369.6139

PATIENT INFORMATION DATE: _____

NAME: _____
First Middle Initial Last

ADDRESS: _____
Street/Box/Apt. City State Zip

PHONE: home _____ work _____ cell _____

Employer: _____ Social Security #_____

Age: _____ Date of Birth: _____ Occupation _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's name (parent's name, if child) _____ Phone: _____

Spouse's Employer: _____

Primary Care Provider (PCP): _____ Address and/or Phone _____

How were you referred to our office?: ☐ PCP ☐ Insurance book ☐ Ad in paper ☐ Internet

INSURANCE INFORMATION

Primary Insurance _____
Plan Name Group ID#

Name of insured_____ Insured's SSN: _____ Insured's DOB: _____

Secondary Insurance _____
Plan Name Group ID#

Name of insured_____ Insured's SSN: _____ Insured's DOB: _____

Medicaid _____
Plan Name Group ID#

ACCIDENT INFORMATION

Is this visit because of an accident? ☐ Yes ☐ No If yes, please give date of accident: _____

If happened on the job, please give the following information: Worker's Compensation Insurance Name, Address, Claim #, Adjuster, Phone:

_____

If we cannot verify worker's compensation status, liability will be the patient's.

EMERGENCY INFORMATION

Emergency contact: name _____ _____ relationship _____ phone_____

RELEASE OF INFORMATION/ PAYMENT AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

_____ _____
Signature Date

Form provided by Healthcommunities.com 1.888.950.0808