WASHINGTON
UROLOGY ASSOCIATES, PLLC

Patient Demographic Form

Patient ID # ______________________ **Patient Chart #** ___________________

PATIENT INFORMATION

Preferred Name	Legal Patient Name	Maiden Name	Birthdate
Patient Address	City	State	Zip
Patient Home Phone	Patient Work Phone	Patient Cell Phone	Email
Employer/School	Social Security Number	Age	Race
Billing Address if different from Patient	Patient Employment Status	Occupation	Primary Language
Name of Referring Physician	Name of PCP	Preferred Pharmacy	Marital Status
Spouse's Name	Spouse's Work Phone	Spouse's Social Security Number	Spouse's Date of Birth

NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE AND OTHER THAN YOUR ADDRESS):

Name	**Home Phone**

INSURANCE INFORMATION

Primary Insurance Name	Insurance Coverage Start Date	Group #	Contract #
Subscriber Name	Sex	Subscriber Birthdate	
Address	City	State	Zip
Patient Relationship to Subscriber of Insurance	Employer Name/ School Name of Insured		
Secondary Insurance Name	Insurance Coverage Start Date	Group #	Contract #
Subscriber Name	Sex	Subscriber Birthdate	Home Phone
Address	City	State	Zip

SIGNATURE REQUESTED

PRIVACY PRACTICES: I acknowledge I have received a copy of Washington Urology Associates' "Notice of Privacy Practices"

Date: _______________________ Signed:____

PHONE MESSAGES: I hereby authorize Washington Urology to leave detailed, personal health information with

_______________________ at the following phone number: __________________________________

ASSIGNMENT OF BENEFITS: Please remember than insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment of medical costs. Payment of the bill is, therefore, your responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to Washington Urology Associates for services rendered to myself.

Date: _______________________ Signed:____

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information by Washington Urology Associates to my referring doctor and insurance company.
Date: _______________________ Signed:____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to Washington Urology Associates for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.
Date: _______________________ Signed:____