East Texas Urology Specialists

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Patient Information:

Today's Date_____

Name_____SSN:_____

Address:_____City/State/Zip_____

Phone number (# where you want to be reached)_____Other#_____

Date of Birth_____Age_____Sex_____Marital Status_____

Spouse's Name_____Spouse's phone#_____

Race: ☐ **Hispanic** ☐ **Caucasian** ☐ **African American** ☐ **Asian** ☐ **Other**

Occupation:_____Work Number_____

Employer:_____Full Time Student **Yes** ☐ **No** ☐

Emergency Contact_____Relationship_____Phone#_____

Who referred you? ☐ **Physician** ☐ **Family** ☐ **Friend** ☐ **Phone Book** ☐ **Insurance Co** ☐ **Other**

Referring Physician's Name_____Primary Physician_____
Reason for visit_____Pharmacy_____

Insurance Information: Patient to fill out completely

Primary Insurance_____ Secondary Insurance_____

Name of Insured_____ Relationship to Insured_____

DOB of Insured_____ Social Security # of Insured_____

If you have Medicare: Are you or your spouse employed full time with a company with more than 20 employees?
Y N

Assignment of Benefits: - If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the necessary information, we will be unable to file your insurance and payment in full will be required.

- Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge any procedures performed will be considered surgery by your insurance company and deductibles and coinsurances may apply.

- Payment is required at time of service.

- I have read the above information and understand that I am responsible for payment for services rendered.

Patient/Guardian Signature_____Date_____