

PATIENT INFORMATION
Please fill out completely

PATIENT NAME _____ M ___ F ___ BIRTHDATE ___/___/___
MAILING ADDRESS _____ CITY _____ ST _____ ZIP _____
PHONE _____ - _____ - _____ CELL _____ - _____ - _____ EMAIL _____
CIRCLE BEST METHOD OF CONTACT OR ADD IT HERE _____

RESPONSIBLE PARTY _____
PARENTS MARITAL STATUS: MARRIED ___ DIVORCED ___ SINGLE ___ WIDOWED ___

MOTHER'S NAME _____ BIRTHDATE ___/___/___
ADDRESS IF DIFFERENT FROM ABOVE _____
PHONE _____ - _____ - _____ CELL _____ - _____ - _____ WORK _____ - _____ - _____
OCCUPATION _____ EMPLOYER _____

FATHER'S NAME _____ BIRTHDATE ___/___/___
ADDRESS IF DIFFERENT FROM ABOVE _____
PHONE _____ - _____ - _____ CELL _____ - _____ - _____ WORK _____ - _____ - _____
OCCUPATION _____ EMPLOYER _____

PRIMARY CARE PHYSICIAN _____ PHONE _____ - _____ - _____
ADDRESS _____ FAX _____ - _____ - _____

PRIMARY INSURANCE _____ ID# _____
GROUP # _____ PHONE _____ - _____ - _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
PRIMARY INSURED _____ BIRTHDATE ___/___/___ SOC SECURITY# _____

SECONDARY INSURANCE _____ ID# _____
GROUP # _____ PHONE _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
PRIMARY INSURED _____ BIRTHDATE ___/___/___ SOC SECURITY# _____

EMERGENCY CONTACT please list someone other than parent of child
NAME _____ PHONE _____ - _____ - _____
ADDRESS _____
RELATIONSHIP TO 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 AT THE TIME OF SERVICE.** I agree to pay a \$10.00 processing fee for any co-payment not made at the time of service. I also agree, in the event my account becomes delinquent and is assigned for collection, that I will be responsible for all costs of collections, collection agency fees, attorney fees and court costs. I understand that if my insurance requires a referral for specialty services, **it is my responsibility to obtain this 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 the referral is obtained. Otherwise, I agree to accept full financial responsibility for any direct or ancillary (lab/radiology) charges related to services rendered.

Date _____ Parent Signature _____