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Monterey Bay Urology Associates

Adult and Pediatric Urology

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PATIENT INFORMATION

Patient Legal Name _____ Gender: Male ___ Female ___
Billing Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____
Email address _____ @ _____
Patient Social Security # _____ Date of Birth _____ Age _____
Referring MD _____ Primary MD _____ Marital Status: S M D W
Employer _____ Work Phone (____) _____ Student: F/T ___ P/T ___
Employer Address _____ City _____ State _____ Zip _____

SPOUSE OR PARENT/GUARDIAN INFORMATION

Spouse Name _____ DOB _____ SS# _____
Parent/Guardian Name (if patient is a minor) _____ DOB _____
Address (if different than patient) _____ City _____ State _____ Zip _____
Parent SS# _____ Home Phone (____) _____ Work Phone (____) _____

INSURANCE INFORMATION

1. Primary Insurance _____ PPO ___ HMO ___ Copay \$ _____
Claims Billing Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Relationship to patient _____
Subscriber Policy/ID# _____ Group # _____

2. Secondary Insurance _____ PPO ___ HMO ___ Copay \$ _____
Secondary Claims Address _____ City _____ State _____ Zip _____
Subscriber Policy/ID# _____ Group # _____

EMERGENCY CONTACT

Name _____ Phone # (____) _____
Address _____ City _____ State _____ Zip _____
Relationship to patient _____

Notice to all patients:

All patients are financially responsible for their bill. If your insurance requires prior authorization, please be aware that your approval must be received before your visit. Any office visits without prior authorization may be billed directly to you. Your signature on this document affirms that the information you have given us is true and correct to the best of your knowledge. Your signature further authorizes the release of any information necessary to process insurance claims on your behalf and assigns payment directly to the physician. This office will make reasonable effort to bill your insurance company, but understand that the patient is ultimately responsible for the payment of services rendered by this office.

Signature _____ Date _____
Relationship to patient _____