

**NORTHWEST ARKANSAS UROLOGY ASSOCIATES
PATIENT INFORMATION**

Patient's Last Name: _____ First Name: _____ MI: _____

Patient's Social Security # _____ Patient's Date of Birth _____

Patient's Address: _____
STREET CITY STATE ZIP

Sex: Male ___ Female ___ Age: _____ Spouse/Parent Name: _____

Email Address: _____

Marital Status (Check One) ____ Married ____ Separated ____ Widowed ____ Single	Student Status (Check One) ____ Full-Time ____ Part-Time ____ Non-Student	Language: (Circle One) English, Spanish, Other Race: (Circle One) African-American, Caucasian, Hispanic, Other: _____ Ethnicity: ___ No-Not Hispanic, Puerto Rican or Cuban ___ Yes-Hispanic, Puerto Rican or Cuban
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Telephone: _____ Cell Phone/Pager: _____

Guarantor Last Name: _____ First Name: _____ MI: _____

Guarantor Social Security # _____ Guarantor Date of Birth _____

Guarantor Address: _____
STREET CITY STATE ZIP

In Case of Emergency Contact Name: _____ Phone _____

Where did you hear about us? _____

INSURANCE INFORMATION

Insurance: _____ Self-Pay: _____
Please have insurance cards ready for receptionist

EMPLOYMENT INFORMATION

Guarantor Employer: _____ Telephone: _____

Spouse's Employer: _____ Telephone: _____

Have you seen a urologist in Northwest Arkansas? Yes ___ No ___ Name: _____
If Yes, approximately how long ago? _____

INSURANCE AUTHORIZATION AND CONSENT FOR EXAMINATION (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE NORTHWEST ARKANSAS UROLOGY ASSOCIATES TO FURNISH MY INSURANCE COMPANY OR COMPANIES, MY ATTORNEY, OR MY PHYSICIAN ANY AND ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE. I HEREBY ASSIGN TO THE CLINIC ALL PAYMENTS FOR MEDICAL SERVICES, SHOULD IT DESIRE TO TAKE SUCH ASSIGNMENT. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I FURTHER AUTHORIZE THE DOCTORS AND STAFF OF NORTHWEST ARKANSAS UROLOGY ASSOCIATES TO EXAMINE ME AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH MEDICAL CARE.

SIGNED: _____ DATE: _____