Patient Profile

Doctor: _____

PATIENT INFORMATION

Name: _____

Address: _____

City,State,Zip: _____

Phone: [ ]Home [ ]Work [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Other

Patient ID #: _____ **Sex:** [ ]M [ ]F

Date of Birth: _____ **Age:** _____

Social Security #: _____

Marital Status: [ ]Married [ ]Single [ ]Divorced

EMail Address: _____

Referring Physician: _____

Primary Physician: _____

Preferred Language:

Race: _____

Ethnicity: **[ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other**

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Phone: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

GUARANTOR

[ ]Same as Patient

Name: _____

Address: _____

City,State,Zip: _____

GUARANTOR EMPLOYMENT

Employer: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

Release of benefits and information: I hereby authorize Bellingham Urology Group to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the provider Bellingham Urology Group. I hereby agree to full responsibility for all expenses incurred by myself or minor child. I understand that a re-billing fee/finance charge complying with Washington State Law will be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. ** Medicare: I understand that my provider is contracted with Medicare and I agree to pay the physician for services Medicare may determine to be "non-covered" or "medically unnecessary". I understand that my provider will obtain my authorization prior to performing services which have limited coverage under Medicare rule.

Signed: _____ **Date** _____ / _____ / _____