



OLD PUEBLO UROLOGY

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PATIENT INFORMATION

ACCOUNT#: _____

NAME: _____ DATE: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP HOME PHONE

EMPLOYER: _____ WORK PHONE: _____

SEX: M F SSN#: _____ BIRTH DATE: _____ AGE: _____
(CIRCLE ONE)

MARITAL STATUS: _____ RELATIONSHIP TO RESPONSIBLE PARTY: _____

PRIMARY CARE/REFERRING PHYSICIAN: _____ ALLERGIES: _____

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER _____
(CIRCLE ONE)

NAME: _____
LAST FIRST

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ SSN #: _____

DATE OF BIRTH: _____ SEX: M F (CIRCLE ONE)

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SUBSCRIBER NAME: _____

ADDRESS: _____ GROUP NAME: _____

SUBSCRIBER ID #: _____

SECONDARY INSURANCE: _____ SUBSCRIBER NAME: _____

ADDRESS: _____ GROUP #: _____

SUBSCRIBER ID #: _____

IN CASE OF EMERGENCY NOTIFY: _____ PHONE #: _____

I understand that I am ultimately responsible for all charges incurred by me. I authorize my insurance company(s) to pay Old Pueblo Urology for those charges I have not paid in full and are filed by the Clinic on my behalf. In the event that my insurance company(s) pays Old Pueblo Urology a fee that I have already paid I understand I will be reimbursed.

I authorize Old Pueblo Urology, Tucson, Arizona to release any medical information required by any insurance company or Worker's Compensation carrier for the processing of any medical claims filed in my behalf.

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR) _____ DATE _____

Worker's Compensation: _____ Date of Injury: _____

Employer: _____

Address: _____

Phone #: _____

Insurance Carrier: _____ Claim #: _____

Address: _____