**PATIENT INFORMATION (PLEASE PRINT CLEARLY)**

LastName_____FirstName_____M.I._____

Address_____City_____State_____Zip_____

SSN#_____-_____-_____D.O.B. _____ / ____ /_____ Home Phone :() _____ - _____

**Sex** :( Please Circle) Female / Male **Marital Status:** (Please Circle) Single Divorced Married Widowed

**GUARANTOR/PARTY RESPONSIBLE FOR PAYMENT OF BILL**

Last Name_____ First Name _____ M.I._____

Address _____City_____ State_____ Zip_____

SSN#_____-_____-_____ D.O.B. _____ / _____ / _____ Sex :( Please Circle) Female / Male

Relationship to Patient: _____ Employer: _____

Employer's Address: _____ Phone _____

**EMERGENCY CONTACT – Complete this section only if contact differs from above guarantor**

| Name: | Relationship to Patient | Home Phone: | Work Phone: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**INSURANCE INFORMATION**

| Primary Insurance Name: | Name on Card: Group #: | Plan #: | Agreement #/S.S. |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Secondary Insurance Name: | Name on Card: Group #: | Plan #: | Agreement #/S.S. |
| _____ | _____ | _____ | _____ |

**VISIT SPECIFIC INFORMATION**

| Referring Physician | Office Phone #: | | Office Fax #: |
|---|---|---|---|
| _____ | _____ | | _____ |
| Address | City | State | Zip |
| _____ | _____ | _____ | |
| Primary Care Physician | Office Phone #: | | Office Fax #: |
| _____ | _____ | | _____ |
| Address | City | State | Zip |
| _____ | _____ | _____ | |

**I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to this physician or supplier. A photocopy of this form will be considered as valid as the original. I acknowledge and authorize North Georgia Urology Center to contact me by all means listed above, including but not limited to email, fax, and telephone**.

**Sign Here Please X** _____