CENTRAL TEXAS UROLOGY

T. Marc Barrett, M.D. Mark W. Story, M.D. Donald A. Stewart, M.D. Jeffrey S. Sanders, M.D.

ALL SERVICES, WHEN APPROPRIATE, ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

PATIENT INFORMATION Date_____

Patient Name_____ Birthdate _____ Age_____
Last First Middle

Address_____City_____State_____Zip_____

Home Phone_____ ☐ Male ☐ Female SSN____/____/____ Driver License #_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____Work Phone_____

Business Address_____City_____State_____Zip_____

Guardian/Spouse's Name_____ Birthdate _____ Age_____

SSN____/____/____Employer_____Work Phone_____

Nearest relative not living with you_____Phone_____

Person to contact in case of emergency_____Relationship_____Phone_____

Please list any allergies_____

Referring Physician_____ Phone_____

Family Physician_____ Phone_____

INSURANCE INFORMATION (please present insurance cards for copying)

Is this visit related to a Workman's Compensation Insurance Claim? ☐ Yes ☐ No

Primary Insurance Company_____ Phone:_____

Secondary Insurance Company_____ Phone:_____

Name of Insured _____

PATIENT AUTHORIZATION (please initial each statement)

_____ I authorize release of any medical information necessary to process my claims to all my insurance companies.

_____ I authorize direct payment of medical benefits to Central Texas Urologic Associates, P. A. for services furnished to me.

_____ I permit a copy of this authorization to be used in place of the original.

_____ I certify the above information is true and correct and realize that I am financially responsible for all medical bills.

Patient Signature_____ Date_____