



The Urology Division of Integrated Medical Services

PATIENT INFORMATION

Patient Name	Middle Initial	DOB	AGE	Sex	Marital Status MO SO DO WO
Address		SSN#			
City, State, Zip		Home Phone Number	Work Phone Number		
Employer					
Primary Care Doctor	Phone	Referring Doctor	Phone		

RESPONSIBLE PARTY

Responsible Party Name	Relationship to Patient	Date of Birth	Guar SSN#
Address- Street		Employer Name	
City, State, Zip		Home Phone #	Work Phone #

EMERGENCY CONTACT

Person to contact in an emergency	Phone
Relationship to Patient	

INSURANCE CONTACT

<u>Name of Primary Insurance</u>	Insured ID/ Policy Number	Group Number
Address	Insurance effective date	Copay Amount
City, State, Zip	Telephone Number	
Policy Holder/ Subscriber	Date of Birth	
<u>Name of Secondary Insurance</u>	Insured ID/ Policy Number	Group Number
Address	Insurance Effective Date	Copay Number
City, State, Zip	Telephone number	
Policy Holder/ Subscriber	Date of Birth	

I hereby authorize the release of any information required in the course of my assessment or treatment. I hereby authorize payment of medical benefits directly to Arizona Urology. I do understand that I am financially responsible for non- covered services, and that I am fully responsible should insurance coverage not exist. Further, I understand that I am responsible for all charges incurred in the collection of this account and will pay all fees involved should this account be placed with a collection service.

Signature _____ Date _____

Tel: 623.512.4390 • Fax: 623.512.4391 • www.arizona-urology.com

West Valley Office: 13555 W. McDowell Road, Suite 203 Goodyear, AZ 85395

Arrowhead Office: 18555 N. 79th Ave, Suite E105 Glendale, AZ 85308