TEXAS UROLOGY SPECIALISTS

Urology Specialists, P.A.

(Please Fill Out Completely)

Date: _____

Home Phone # _____
Cell Phone # _____
Work Phone # _____
e-mail: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W Sex: Male Female

Patient Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient Employer: _____ Occupation: _____

Spouse Name: _____ Ok to release Medical Information to spouse? ☐ YES ☐ NO

Spouse Employer or School if Child: _____ Job Title: _____ Phone: _____

*Applies only to parents of minor children or children insured under the parents' insurance

*Parent Name: _____ *Parent Name: _____

Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy Name / Location: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian/Indian/Pakistani/Sri Lankan ☐ Chamorran ☐ Chinese ☐ Fiji Islander ☐ Filipino ☐ Guamanian NOS ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Kampuchean/Cambodian ☐ Korean ☐ Laotian ☐ Melanesian NOS ☐ Micronesian NOS ☐ Samoan ☐ Tahitian ☐ Thai ☐ Tongan ☐ Vietnamese ☐ Other _____

RESPONSIBLE PARTY INFORMATION

Primary Insurance

Name of Insured: _____
Date of Birth of Insured: _____

Policy #: _____ Group #: _____
Insurance Address: _____
Customer Service Phone Number: _____

Secondary Insurance

Name of Insured: _____
Date of Birth of Insured: _____

Policy #: _____ Group #: _____
Insurance Address: _____
Customer Service Phone Number: _____

Signature of Patient

X _____

Signature of Responsible Party

X _____