FOOTHILLS UROLOGY

400 Indiana Street, Suite 300 • Golden, Colorado 80401
Phone: (303) 985-2250 • Fax: (303) 985-2586

Please Print the Following Information: Date: ______________

PATIENT INFORMATION:

Last Name____ First Name_____________________________________ MI_____

Address ____ City____________________________ State_____ Zip_________

Sex_____ Birth Date_____________ Age_____ Marital Status_______________ Social Security Number _________________________

Home Phone ____ Work Phone ____

Employer____ Employer Address____

INSURANCE INFORMATION:

Primary Company ____

Policy Number___________________________________ Group Number____________________________ Effective Date____________

Secondary Insurance Company ____

Policy Number___________________________________ Group Number____________________________ Effective Date____________

IF POLICY HOLDER IS NOT THE PATIENT, PLEASE FILL IN THE FOLLOWING:

Policy holder's name: Last ___________________________ First_________________________ Middle Initial_____ Birth Date__________

Social Security Number ___________________________ Phone Number_________________ Relation to Patient____________________

Policy holder's Employer____ Employer Phone Number__________________________

Employer Address_______________________________________ City_____________________________ State_____ Zip____________

REFERRED BY:

Physician (Name)____ Other Source________________________________

IN CASE OF EMERGENCY:

Name of Person to Contact ____ Phone Number__________________________

Relation to patient ____

PLEASE READ AND SIGN THE FOLLOWING

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Foothills Urology. I understand that as a courtesy, my insurance carrier will be billed; however, it is my responsibility to follow up on delinquent claims.

Signature ____ Date___________________

I understand and agree that if care with Foothills Urology requires referral, it is MY RESPONSIBILITY to see that the referral is current PRIOR to receiving care at the office of Foothills Urology. If no referral is present in advance, I agree to pay for charges at the time service is rendered.

Signature ____ Date___________________