UROLOGICAL CONSULTANTS
A Division of Chesapeake Urology Associates

Name:	**Date of Birth:**
Address:	**Social Security #:**
	Sex:
City:	**E-Mail Address:**
State: **Zip:**	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Referring Physician:	**Primary Care Physician:**
Your Pharmacy:	**Pharmacy Phone:**
Employment Status: (One): Retired Full Time Part Time Military Self None	
Marital Status: (One): Married Divorced Single Separated Widowed	
Race: American Indian or Alaska Native / Asian / Black or African American/ Native Hawaiian / White / Refused to Report-Unreported / Other Pacific Islander / More than one race	
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Refused to Report	
Preferred Language (Please Print):	
Notification Method for Preventive Health Reminders: Postal Mail / Phone / Web Message	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security#:**
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**
Co-Pay Amount:	**Co-Pay Amount:**

Authorization to pay benefits to physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Urological Consultants a Division of Chesapeake Urology when he accepts assignment.

Authorization to release medical information. I hereby authorize my Provider, Urological Consultants a Division of Chesapeake Urology to release any information necessary for my course of treatment.

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Signature (patient or parent if minor) Date