Urology Associates of Norwalk, PC Date:_____

Circle the Physician you are seeing: *Dr. Batter* *Dr. Bernie* *Dr. Dodds* *Dr. Serels*

Last Name:_____ **First name:**_____**MI:**_____
(Name as it appears on your Insurance Card)

Birthdate:_____ **Age:**_____ **Gender: (M) (F)** Marital Status: (S) (M) (W) (D)

Address: _____

Home phone:_____ **Cell phone:**_____
___YES, I would like to receive appointment confirmations via text message

Social Security #:_____ Retired: (Y) (N) **Work phone:**_____

Employer:_____

If Student, School name_____Full/Part time

Referring/Primary Physician:_____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name:_____Relationship to patient:_____

Address: ( ) same or _____

Home phone:_____ Cell phone:_____

Birthdate:_____ Social Security #:_____

EMERGENCY CONTACT:_____**Phone:**_____

PRIMARY INSURANCE INFORMATION

**REFERRALS: If your insurance requires a referral from your PCP and is not presented at the time of service, Patient will be responsible for further payment of services rendered.

Medicare #:_____ Medicaid #:_____

Insurance Co._____Phone:_____

Address:_____

Group #:_____ Member ID #:_____

Policy holder:_____Relationship to Patient: (Self) (Spouse) (Dependent)

Birthdate:_____ Gender (M) (F)

SECONDARY INSURANCE INFORMATION

Medicare #:_____ Medicaid #:_____

Insurance Co._____Phone:_____

Address:_____

Group #:_____ Member ID #:_____

Policy holder:_____Relationship to Patient: (Self) (Spouse) (Dependent)

Birthdate:_____ Gender (M) (F)

I authorize that payment of insurance benefits be made to Urology Associates of Norwalk, PC for services rendered for me. I authorize any medical information about me be released to my insurance company or it's agents as needed to determine benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any fees in the collection of unpaid amounts.

Signature:_____ Date:_____