Patient Information

Patient Name: ________________________________
(First) (Middle) (Last)

Maiden Name:________________________________

Address: ________________________________

____
City State Zip

Date of Birth: ____________________ Male / Female

Place of Birth: ____________________
City State

Social Security Number: __________________________

Home Phone: (____) ____________________

Is it ok to leave a message? ☐ YES ☐ NO

Mobile Phone: (____) ____________________

Is it ok to leave a message? ☐ YES ☐ NO

Work Phone: __________________________

Is it ok to leave a message? ☐ YES ☐ NO

Which phone would you prefer to be contacted at?

☐ HOME ☐ CELL ☐ WORK

Email Address: ______________________________

Patient Demographics

Marital Status: ☐ Married ☐Divorced

☐Annulled ☐Legally Separated

☐Interlocutory ☐Never Married

☐Domestic Partner ☐Widowed

Race: ☐ White

☐ Asian ☐ Black or African American

☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander

☐ Other

Ethnicity: ☐ Hispanic or Latino

☐ Non-Hispanic or Latino

☐Declined to specify

Language Preferred: ☐ English ☐ Spanish ☐ Other

Employee Status: ☐ Full Time ☐ Part Time

☐ Retired ☐ Other

*If Working Full Time or Part Time:

Employer Name: ______________________________

Patient Referral Information

☐Self Referred

☐Friend ☐Radio ☐Media

☐Other ________________________

☐Referring MD: ________________________

Other Current Physicians (This includes all current Specialists and/or Family Practice Physicians):

Name Specialty

____
____
____
____
____
____

Urology Cancer Center and GU Research Network

Responsible Party Information

☐ Responsible Party is same as Patient Information

*Please fill out the following if information is different than Patient Information

Subscriber Name: ______________________________
First Last

Subscriber Address: ______________________________

____
City State Zip

Subscriber Date of Birth:______________________________

Subscriber Social Security #:______________________________

Home Phone: (   ) ______________________________

Mobile Phone: (   ) ______________________________

Work Phone: (   ) ______________________________

Patient Insurance Information

*Please provide insurance cards, photo ID and prescription cards to the receptionist

Primary Insurance: ______________________________

Secondary Insurance: ______________________________

Prescription Drug Plan: ______________________________

Patient's Preferred Pharmacy

Name: ______________________________

Address: ______________________________

____
City State Zip

Pharmacy Phone: (   ) ______________________________

Medicare Required Questions

*Are you covered by Medicare? ☐ YES ☐ NO

(If **YES** please complete the following questions. If **NO** skip to next section.)

Are you or your spouse employed? ☐ YES ☐ NO

If yes, do you have group health coverage through an employer? ☐ YES ☐ NO

Are you entitled to Medicare because of Disability or End State Renal Disease? ☐ YES ☐ NO

Is this illness or injury the result of an automobile accident or other injury? ☐ YES ☐ NO

Is this illness or injury the result of an accident or illness that occurred at work? ☐ YES ☐ NO

Has treatment and payment been authorized by the Veteran's Administration? ☐ YES ☐ NO

Are you entitled to any benefits under the Federal Black Lung Program? ☐ YES ☐ NO

Notice of Privacy Practices

I was provided the opportunity to review and receive a copy of the Notice of Privacy Practices of UCC

☐ YES ☐ NO

Acknowledgment

To the best of my knowledge, all the information provided is true and accurate.

Name of Patient: (Please Print)

____

Patient Signature:

______________________________ Date: ____________

Living Will/POA

Do you have a living will? ☐ YES ☐ NO

Do you have a Power of Attorney? ☐ YES ☐ NO

If yes who is your POA? ______________________________