

# INFORMATION FORM

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Account No. \_\_\_\_\_ New Patient \_\_\_\_\_ Information Update \_\_\_\_\_

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

Patient's Birth Date \_\_\_\_\_ Male Female SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status S M W D

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I prefer to be called at: Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_

Who referred you to our office? \_\_\_\_\_

Your Family Physician \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Work Number \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have an Advanced Directive (Living Will)? YES NO If so, may we have a copy?

Preferred Pharmacy: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

## POLICYHOLDER(S) / INSURED(S) INFORMATION

• **PRIMARY INSURANCE** \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Policyholder Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Policyholder Address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Policyholder Employer Name \_\_\_\_\_

• **SECONDARY INSURANCE** \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Policyholder Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Policyholder Address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Policyholder Employer Name \_\_\_\_\_

I hereby authorize payment of medical benefits to Dayton Physicians, LLC – Urology Division. I authorize the release of any medical information necessary to process a claim. I acknowledge that I am financially responsible for all charges not covered by insurance, Medicare, or Medicaid, and for all collection costs. I have read and understand the above statements.

Signature \_\_\_\_\_ Date \_\_\_\_\_