

UROLOGY ASSOCIATES, S.C.

Dr. Roger Rives • Dr. David DiDomenico

Keith Ballinger PA-C

500 Health Center Drive Suite 305

Mattoon, IL 61938

217.348.186

WELCOME TO OUR OFFICE

Today's Date _____

Name _____

Last

First

Middle Initial

Maiden Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Birth Date: _____

M ___ F ___ Age: ___ Marital Status: ___ Race: _____

SS# _____ # of children & Ages _____

Employer: _____ Occupation: _____

Address _____ Phone: _____

City _____ State _____ Zip _____

Mother's Maiden Name _____

ALLERGIES: ___ Yes ___ No If yes, please list _____

Are you currently taking any medications? ___ Yes ___ No If yes please list: _____

Name of Referring Doctor: _____ Primary Dr.: _____

IF YOU ARE MARRIED, PLEASE COMPLETE THIS SECTION:

Spouse's Name: _____ Birth Date _____

SS# _____ Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip _____ Phone: _____

IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE, PLEASE COMPLETE:

Responsible Party : _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone _____ SS# _____ DOB _____
Employer _____ Occupation _____ Phone _____
Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY, CONTACT: _____

Relationship _____ Address _____ City _____

State _____ Zip _____ Phone _____

Do you have a living will? ___ Yes ___ No Power of Attorney? ___ Yes ___ No

If yes, Name: _____ Phone # _____

If you are new to our office, how did you hear about us? _____

Do you have an answering machine? ___ Yes ___ No

If yes, may we leave messages on your machine regarding call backs to the office? _____

INSURANCE INFORMATION

Primary Insurance Number and Name: _____

Secondary Insurance: _____

HMO Number _____ Medicare Number _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARDS IN YOUR CHART.

I authorize Urology Associates to furnish information to insurance carriers concerning my illnesses and/or treatments, and I assign to the doctor all payments for medical services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

I authorize release of my medical information to the following individuals: _____

I authorize:

1. The physician and the staff to do any medical treatment, test, or care deemed necessary.
2. The release of medical information necessary to process medical claims.

ALL SERVICES ARE TO BE PAID AT THE TIME OF VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ACCOUNTS OVERDUE 180 DAYS (6 MONTHS) MAY INCUR ADDITIONAL CHARGES INCLUDING COLLECTION COSTS AND ATTORNEY FEES.

Date _____

Signature of the Patient or Guardian