SanJuanUrology
World Class Care In Western Colorado

San Juan Urology

Date____________________ Patient #____________________________________

Name____________________________________Birthdate________________Age____________

Mailing Address____

City ____ State __________ Zip___________

Male ☐ Female ☐ Minor ☐

Single ☐ Married ☐ Divorced ☐ Widowed ☐

SSN#____________________________ Drivers License#_____________________________________

Home Phone _______________ Cell Phone __________________ Work Phone ___________________

Patient Occupation______________________ Employer Name________________________________

Emergency Contact_____________________________________

Relationship__________________ Phone#________________________

Referring Physician__________________________ Pharmacy/location___________________________

Primary Insurance____________________________________

Policy#_________________________ Group#___________________________

Address____

City ____ State __________ Zip___________

Name of Insured if other than Patient______________________________________

Relationship_________________

Birth date ___________ SSN#_______________________ Phone____________________

Secondary Insurance ________________________________

Policy#_________________________ Group#___________________________

Name of Insured if other than Patient________________________________

Relationship_________________

Birth date ___________ SSN#_______________________ Phone____________________

Responsible Party (If other than Patient)

Name____ Relationship_____________________

Address____

City ____ State __________ Zip___________

Phone #___________________ SSN#_________________________ Birthdate______________

Insurance ________________________________ Policy #_________________ Group#__________

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me (or child) during the period of such care, to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the doctor or group, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf. Medicare/Medicaid-I request that payment of authorized Medicare benefits be made either to me or on my behalf to San Juan Urology, for any services furnished me by San Juan Urology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services.

Patient Name (please print) _________________________________

Signature of Patient or Parent/Guardian ____

Date _____________________