UNION GENERAL UROLOGY

AFFILIATE OF: UNION GENERAL HOSPITAL, INC.

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Ziyad H Mugharbil MD (Mur) all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insuranc

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____