CORPUS CHRISTI UROLOGY GROUP

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_____ ALEXANDER J. ASHMORE, M.D. _____ ALAN A. NISBET, M.D.

PATIENT # __________ COMPUTER # __________ DATE __________

PLEASE BE SURE ALL INFORMATION IS COMPLETE

PATIENT'S LAST NAME: __________ FIRST: __________ M.I.: __________

DOB: ___/___/___ AGE: ______ SEX: M OR F SS# __________

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME: __________ DOB: ___/___/___ SS# __________ PHONE: __________

ADDRESS: __________ CITY/STATE/ZIP __________

EMPLOYER: __________ OCCUPATION: __________

EMPLOYER'S ADDRESS: __________ EMPLOYER'S PHONE: __________

MOTHER'S NAME: __________ DOB: ___/___/___ SS# __________ PHONE: __________

ADDRESS: __________ CITY/STATE/ZIP __________

EMPLOYER: __________ OCCUPATION: __________

EMPLOYER'S ADDRESS: __________ EMPLOYER'S PHONE: __________

IN CASE OF EMERGENCY NOTIFY: __________ PHONE: __________

ALLERGIES: __________

REFERRING PHYSICIAN: __________ FAMILY PHYSICIAN: __________

FAMILY PHARMACY: __________ PHONE: __________ DIAGNOSIS: __________

IF WE HAVE COPIED YOUR INSURANCE CARD, YOU MAY LEAVE THIS PORTION BLANK

MEDICARE NUMBER: __________ MEDICAID NUMBER: __________

INSURANCE COMPANY: __________ POLICY HOLDER: __________

ADDRESS: __________ RELATIONSHIP: __________

PHONE NUMBER: __________ POLICY: __________ GROUP: __________

OTHER INSURANCE: __________ POLICY HOLDER: __________

ADDRESS: __________

PHONE NUMBER: __________ POLICY: __________ GROUP: __________

ASSIGNMENT OF INSURANCE: I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his service. I understand I am financially responsible for charges not covered by this assignment.
AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION: I hereby authorize the above named physician to obtain any medical information or records which will aid in the treatment or diagnosis of my illness. I also authorize the above named physician to release any information acquired in the course of my examination or treatment to other physicians or to insurance companies.

PLEASE CIRCLE METHOD OF PAYMENT FOR TODAY'S VISIT: CHECK CASH CREDIT CARD OTHER __________

RESPONSIBLE PARTY'S SIGNATURE __________