UNIVERSITY PEDIATRIC UROLOGY
PATIENT INFORMATION

Patient's Name ______________________________ Date of Birth ______________

Patient's Social Security# ______________________ Patient's Sex _____ Male _____ Female

Street Address ______________________________ City______________ State ________ Zip__________

Home Phone# ______________________ Cell Phone #______________________

FATHER/GUARDIAN

Name______________________

Date of birth______________________

Social Security#______________________

Address______________________

City/State/Zip______________________

Phone# ______________ Cell#______________

Employer______________________

Address______________________

Work Number______________________

MOTHER/GUARDIAN

Name ______________________

Date of birth______________________

Social Security#______________________

Address ______________________

City/State/Zip ______________________

Phone# ______________ Cell#______________

Employer ______________________

Address______________________

Work Number______________________

Emergency Contact ______________________ Phone#______________ Relationship______________

Pediatrician Name ______________________ Phone#______________________

Referring Doctor (if different from Pediatrician) ______________________ Phone# ______________

Pharmacy Name ______________________ City______________ Phone#______________

INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)

Does patient have TennCare or Medicaid Coverage? ________

PRIMARY INSURANCE ______________________________

Address______________________ City______________ State __________ Zip__________

Subscriber's Name______________________ Date of Birth______________________

Relationship to patient ______________________ Group Name______________________

Policy Number ______________________ Group Number ______________________

SECONDARY INSURANCE ______________________________

Address______________________ City______________ State __________ Zip__________

Subscriber's Name______________________ Date of Birth______________________

Relationship to patient ______________________ Group Name______________________

Policy Number ______________________ Group Number ______________________

I request that payment of authorized Medicare, Medicaid and/or commercial insurance benefits be made to University Pediatric Urology, PC for any service furnished to me by UPU's physicians and/or their staff. I authorize any holder of medical information about me to release to those persons or companies representing a legitimate request. I authorize UPU to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due to UPU. These amounts could include annual deductibles, co-payments, charges denied as not covered by my insurance program, and charges denied for services determined as not medically necessary. I further understand that if UPU incurs any fees associated with collection reimbursement on my account, I will be responsible for paying those fees.

______________________ ______________________ ______________

Parent or Legal Guardian | Relationship to patient | Date

UNIVERSITY PEDIATRIC UROLOGY
CONSENT FOR TREATMENT FOR A MINOR

Patient Name____ Date of Birth______________________

I, the undersigned, parent/guardian of ____, a minor, do hereby authorize medical treatment and diagnostic procedures provided by the physicians and/or employees of University Pediatric Urology, PC. I understand this could include resident physicians who are under the direct supervision of UPU, but not employees or agents of this physician or UPU. This consent shall remain effective for 12 months from the date of signature or until revoked in writing.

____ ________________________

Parent/Guardian Date

University Pediatric Urology must receive permission from a child's parent/guardian to let another individual bring the child in for medical treatment and to discuss medical information. Please provide us with the name, relationship and phone number for any individual who has your permission to bring the child to the office, and/or discuss medical information.

Name	Relationship	Phone Number

*****Children under 18 years of age will NOT been seen without a guardian or person authorized by the guardian.*****

Payment for any Co-pays, Co-insurance or charges for services rendered in case of no insurance are due at the time of the appointment and will be the responsibility of the adult accompanying the patient.

CONTACT RECORD

Please contact me as follows:

___ Home Phone: (____) ______________ ___Cell Phone: (____) ______________

___Work Phone: (____) ______________ ___Other Phone : (____) ______________

___ Okay to leave message with healthcare information

___ Leave message with call back number only

___ Do **NOT** leave messages

___ No restrictions – speak with whomever necessary in my behalf

___Leave message on home answering machine

Note: If we are unable to reach you by another means, we will send information through the U.S. Postal Service to the home address we have on file.

____ ________________________

Parent/Guardian Date