

# UNIVERSITY PEDIATRIC UROLOGY

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## PATIENT INFORMATION

DATE \_\_\_\_\_ PRIMARY CARE PHYSICIAN \_\_\_\_\_  
NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
(Last) (First) (MI)  
ADDRESS \_\_\_\_\_ SS# \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ AGE \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

### FATHER / GUARDIAN

### MOTHER / GUARDIAN

NAME _____ (Last) (First) (MI)	NAME _____ (Last) (First) (MI)
BIRTHDATE _____	BIRTHDATE _____
SS# _____	SS# _____
ADDRESS _____	ADDRESS _____
CITY/STATE _____	CITY/STATE _____
ZIP _____ PHONE _____	ZIP _____ PHONE _____
EMPLOYER _____	EMPLOYER _____
ADDRESS _____	ADDRESS _____
CITY/STATE _____	CITY/STATE _____
ZIP _____ PHONE _____	ZIP _____ PHONE _____

### Relative or friend to contact in case of emergency. Someone who does not reside in your home

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## INSURANCE INFORMATION

**PRIMARY INSURANCE CO** \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP ID# \_\_\_\_\_ POLICY HOLDER'S DOB \_\_\_\_\_

**SECONDARY INSURANCE CO** \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP ID# \_\_\_\_\_ POLICY HOLDER'S DOB \_\_\_\_\_

TENNCARE COVERAGE YES \_\_\_\_\_ NO \_\_\_\_\_ WHICH COMPANY \_\_\_\_\_

## AUTHORIZATION FOR RELEASE

I/we request that payment of authorized benefits including government sponsored programs, private insurance, and any other health plans be made to University Pediatric Urology, PC for any service furnished by Dean Preston Smith, M.D., David E Hill M.D., and/or their staff. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request of such information, any information needed to determine these benefits. I further authorize the release of medical information needed to provide any and all necessary treatment. I authorize University Pediatric Urology to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance company or government program. I authorize my insurance company or government agency to give any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of the assignment and release is to be considered as valid as the original. I/we agree to pay all applicable balances not paid by the third party payer. If no third party payer exists, I/we agree to pay all balances for services rendered.

Patient (if 18 or older) Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_