

**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

MOTHER/GUARDIAN

Name _____

Name _____

Date of birth _____

Date of birth _____

Social Security# _____

Social Security# _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Phone# _____ Cell# _____

Phone# _____ Cell# _____

Employer _____

Employer _____

Address _____

Address _____

Work Number _____

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

*Please complete both sides. Over▶

**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

Name Relationship Phone Number

Name Relationship Phone Number

*****Children under 18 years of age will NOT be 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