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

*****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

*Please complete both sides. Over▶