



Urology Department Dr. Carl Walker

4950 State Road 23, Granger, IN 46530 • 574/243-4450 • 574/243-4405

For Internal Use Only
PFID Number

UROLOGY DEPARTMENT

PATIENT INFORMATION

Social Security Number: _____ Date of Birth: _____
 Last Name: _____ First Name _____ M.I.: _____ Maiden or Nick Name: _____
 Address: _____ Apt.: _____
 City: _____ State: _____ Zip: _____
 Home Phone #(____) _____ Work Phone #(____) _____ E-mail _____
 Marital Status Single Married Divorced Widowed Other Cell # _____

PATIENT'S EMPLOYER INFORMATION

Employer's Name: _____ Patient's Occupation: _____
 Address: _____ If Student: Full Time Part Time
 City: _____ State: _____ Zip: _____

INSURANCE INFORMATION – PRIMARY / SECONDARY / OTHER

★★★PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST★★★

Do you have health insurance? Yes No
 Primary Insurance Company Name: _____
 Please indicate the policy holder for the primary insurance: Self Parent Spouse Other _____
 Secondary Insurance Company Name: _____
 Please indicate the policy holder for the secondary insurance: Self Parent Spouse Other _____

SPOUSE'S INFORMATION OR PARENT'S INFORMATION (If patient is covered by parent's insurance)

Spouse's or Parent's Name: _____ Spouse's or Parent's Birth Date: _____
 Spouse's or Parent's SS#: _____ Employer's Phone #: _____
 Spouse's or Parent's Employer: _____
 Spouse's or Parent's Employer's Address: _____
 City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Please list the nearest living relative or friend other than your Spouse or parent.

In case of an emergency, we may contact:

 (____) _____
Telephone number Relationship to patient

HOW DID YOU FIND OUT ABOUT US?

- From a current patient? (CP)
Name: _____
- Advertising (AD) Yellow pages (YP)
- Internet (IT)
- Referral by Physician (RP)
Name: _____
- Health Plan / Insurance Directory (INS)

AUTHORIZATION FOR PAYMENT

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to the _____, its successors and assigns, or any individual it may designate for services provided.
 I further agree to pay all costs of collection, including attorney's fees, associated with the collection of any amount due to services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the _____, its successors and assigns and any individual it may designate for any balance not covered by insurance.

Signature of Patient or Parent of Minor Date

AUTHORIZATION FOR MEDICARE

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to: _____
 for services furnished to me by the provider.
 I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature Date