Austin:
1301 Barbara Jordan Blvd Suite 302 Austin Texas 78723

Cedar Park:
1301 Medical Parkway Suite 310 Cedar Park Texas 78613

CHILDREN'S UROLOGY

Patient Information

Patient

Last Name:_____First Name:_____Nickname: _____

Date of Birth:_____/_____/_____Patient SSN:_____—_____—_____Gender: ❑ **Male** ❑ **Female**

With whom does the child live?

Last Name: _____First Name: _____ Relation_____

Race: □American Indian or Alaskan Native □Asian □Black or African American □Native Hawaiian or other Pacific Islander □White □Decline □Other:_____

Ethnicity: □Hispanic/Latin □Not Hispanic/Latin □Declined □Other:_____

Who referred you? (Please circle one) **FAMILY FRIEND PHYSICIAN REFERRAL WEBSITE**

Name of person or Physician referring you: _____Phone:_____

Primary Care Physician (PCP): _____Phone:_____

Parent 1

Last Name:_____First Name:_____DOB: _____
Marital Status: Single/Married/Divorced/Widowed

Street Address_____Social Security# _____

City_____State_____Zip_____

Primary Phone:_____Work Phone:_____Email_____

Parent 2

Last Name:_____First Name:_____DOB: _____
Marital Status: Single/Married/Divorced/Widowed

Street Address_____Social Security# _____

City_____State_____Zip_____

Primary Phone:_____Work Phone:_____Email_____

Emergency Contact
Last Name: _____First Name_____Relation_____

Primary Number_____Secondary_____

Primary Insurance

Policy Holder
Last Name:_____First Name:_____Policy Holder's Birth Date:____/_____/ _____

Insurance Provider:_____Policy Holder's SSN:_____—_____— _____

Group number:_____Insurance ID Number _____

Secondary Insurance

Policy Holder
Last Name:_____First Name:_____Policy Holder's Birth Date:____/_____/ _____

Insurance Provider:_____Policy Holder's SSN:_____—_____— _____

Group number:_____Insurance ID Number _____

I hereby give authorization for payment of insurance benefits to be made directly to Children's Urology for services rendered. **I understand that I am financially responsible for all charges whether or not they are covered by insurance**. In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is valid as the original.

Printed Name: _____

Signature: _____ Date: _____