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MIU Patient Information Form

appointment date/time _____ / _____

PATIENT'S NAME (LAST, FIRST, M.I.) BIRTHDATE AGE

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP) SEX M F

HOME PHONE WORK PHONE CELL PHONE EMAIL ADDRESS

SOCIAL SECURITY NO. PRIMARY CARE PHYSICIAN REFERRING PHYSICIAN

MEDICARE HIC # IS INSURED RETIRED? RETIREMENT DATE PATIENT'S WORK PHONE/EXT. YES NO

SUBSCRIBER'S NAME (LAST, FIRST, M.I) SUBSCRIBER'S BIRTHDATE RELATIONSHIP TO PATIENT

SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP)

SUBSCRIBER'S EMPLOYER PRIMARY INSURANCE NAME

PRIMARY INSURANCE ADDRESS (CITY & STATE) PRIMARY INSURANCE PHONE

CONTRACT NUMBER GROUP SERVICE CODE

SECONDARY INSURANCE NAME SECONDARY INSURANCE (CITY & STATE) SECONDARY INSURANCE PHONE

SECONDARY INSURANCE SUBSCRIBER NAME BIRTHDATE OF SECONDARY SUBSCRIBER RELATIONSHIP TO INSURER

CONTRACT NUMBER GROUP SERVICE CODE

ALLERGIES TO MEDICATION:

NAME OF NEXT OF KIN OR EMERGENCY CONTACT / RELATIONSHIP TO PATIENT

NEXT OF KIN OR EMERGENCY CONTACT'S ADDRESS / PHONE #

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN - I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services described below but not to exceed the reasonable and customary charge for these services. "I UNDERSTAND THE PROVIDER'S CHARGE MAY EXCEED THE PRIVATE INSURANCE CARRIER PAYMENT, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT."

ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment

SIGNED (PATIENT OR PARENT IF A MINOR)