XR #:_____

PATIENT INFORMATION (MINOR)
(Please fill in completely)

_____
Full Legal Name: Last Name First Name Middle

_____
Street Address City State Zip

(_____)_____ _____ _____ _____
Home Phone Sex Date of Birth Patient's Social Security #

With whom does the child reside?_____

Mother's Name_____ Date of Birth_____

_____ _____
Street Address City State Zip Mother's Social Security #

Mother's Employer _____ Work Phone (_____)_____

_____
Street Address City State Zip

(_____)_____ Mother's e-mail: _____@_____._____
Mother's Cell Phone

Father's Name_____ Date of Birth_____

_____ _____
Street Address City State Zip Father's Social Security #

Father's Employer _____ Work Phone (_____)_____

_____
Street Address City State Zip

(_____)_____ Father's e-mail: _____@_____._____
Father's Cell Phone

Preferred contact #: (circle one) Home (Mother's or Father's) Work (Mother's or Father's) Cell (Mother's or Father's)

Patient's family physician? _____(_____)_____
Full Name Address Phone

Who referred patient to our office? (Family Physician / ER /Friend, etc.) _____

Medical Insurance Information **(Please bring your insurance card)**

Primary Insurance Carrier Subscriber Name Policy ID # and Group ID #

Secondary Insurance Carrier Subscriber Name Policy ID # and Group ID #

Authorization to Release Information and Financial Acceptance

I here by authorize Northwest Columbus Urology, Inc., Gregory S. Knudson, MD, to release any information that may be required to obtain reimbursement. I certify that the information furnished, by me or my representative, as true and correct.

I understand that I am financially responsible for payment of all charges left unpaid by my insurance carrier or other sources. I will uphold any payment schedule agreement negotiated with Northwest Columbus Urology, Inc., Gregory S Knudson, MD.

_____ _____
Parent Signature/P. O. A./ Legal Guardian **Date**