**EL CAMINO UROLOGY MEDICAL GROUP, INC.**
**A Division of USNC**

PATIENT NAME: _____ DATE: _____
FIRST M.I. LAST

DATE OF BIRTH: _____ AGE: _____ ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ N/A - CHILD

STREET ADDRESS: _____ HOME PHONE: (_____)_____

CITY: _____STATE: _____ ZIP: _____ CELL PHONE: (_____)_____

PATIENT'S SOC. SECURITY #: _____ BUS. PHONE: (_____)_____

EMPLOYED BY: _____ OCCUPATION: _____

PREFERRED METHOD OF CONTACT: ☐ EMAIL ☐ PHONE: HOME / WORK / CELL

RACE: ☐ CAUCASIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

☐ HISPANIC ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ OTHER_____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON HISPANIC OR LATINO

PREFERRED LANGUAGE:_____ EMAIL ADDRESS:_____

NAME OF SPOUSE OR PARENT: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSE EMPLOYED BY: _____ SPOUSE'S SSN: _____

SPOUSE'S PHONE #:_____

FAMILY PHYSICIAN: _____ PH: (_____)_____

REFERRED BY: _____ PH: (_____)_____

EMERGENCY CONTACT: _____ _____ (_____)_____
NAME RELATIONSHIP PHONE NO.

WE BILL ALL INSURANCES IF PROVIDED WITH PROPER INFORMATION. PLEASE PRESENT ALL INSURANCE CARDS TO US.

MANAGED CARE PATIENTS: IT IS YOUR RESPONSIBILITY TO KEEP THIS OFFICE INFORMED REGARDING REFERRALS, AUTHORIZATIONS, AND ANY SPECIAL X-RAY OR LAB REQUIREMENTS.

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| PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:<br>I authorize the release of any medical or other information necessary to process this claim or for preauthorization requirements.<br><br>Signed:_____<br><br>Date:_____ | INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:<br>I authorize payment of medical benefits to my physician for services rendered.<br><br>Signed:_____<br><br>Date:_____ | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:<br>I have read the Notice of Privacy Practices for El Camino Urology Medical Group Inc.<br><br>Signed:_____<br><br>Date:_____ |