

UROLOGY SPECIALISTS OF SANTA BARBARA

504 W. Pueblo St., #102 • Santa Barbara, CA 93105

(805) 687-7719 • FAX (805) 682-2971

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ ZIP: _____
Mailing Address (if different): _____
Home Phone: _____ Work Phone: _____
Cell phone : _____ E-mail: _____
Employer: _____ Occupation: _____
Social Security #: _____ Driver's License #: _____

SPOUSE, PARENT OR GUARDIAN INFORMATION

Name of spouse, parent or guardian (circle): _____
Address (if different): _____ City: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone: _____ Cell Phone _____
Employer: _____ Occupation: _____
Social Security #: _____

INSURANCE INFORMATION

Primary Insurance Co: _____
Name of Insured: _____
Plan or Policy #: _____ Group #: _____ Co-pay Amount: \$ _____
Secondary Insurance Co: _____
Name of Insured: _____
Plan or Policy #: _____ Group #: _____

OTHER INFORMATION

Notify in case if an emergency: _____
Relationship to you: _____ Their phone #: _____

1. I authorize my physician or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by this office and that I am financially responsible for the full amount of charges that are not covered by insurance benefits (co-pays, deductibles and non covered expenses). Co-payments are due at the time of service.

2. There is a \$20.00 charge for any returned checks.

3. A \$25.00 charge may be rendered for missed appointments or appointments not cancelled with at least 24 hours notice.

Signature _____ Date _____