UROLOGY SPECIALISTS OF SANTA BARBARA

504 W Pueblo St., #102 Santa Barbara, CA 93105
805-687-7719 Fax 805-682-2971

PATIENT'S NAME _____ HOME PHONE # ( ) _____

CELL PHONE: _____

ADDRESS _____ WORK PHONE# ( ) _____

CITY _____STATE _____ DATE OF BIRTH _____ AGE _____

ZIP CODE _____ SEX (M/F) _____ SOCIAL SECURITY # _____

EMPLOYER _____ DRIVER'S LICENSE # _____

SPOUSE'S NAME _____ E-MAIL ADDRESS _____

SPOUSE'S DATE OF BIRTH _____ MARITAL STATUS _____

PERSON RESPONSIBLE FOR PAYMENT

ADDRESS _____ HOME PHONE _____

EMPLOYED BY _____ SOCIAL SECURITY # _____

OCCUPATION _____ WORK PHONE # _____

NOTIFY IN CASE OF EMERGENCY

NAME _____ PHONE # _____

ADDRESS _____ RELATION TO PATIENT _____

_____ CASH PAY _____ PRIVATE INSURANCE _____ MEDICARE _____MEDI-CAL _____WORK COMP

IS THIS WORK RELATED? _____ DATE OF INJURY_____ EMPLOYER _____

PRIMARY INSURANCE _____ NAME OF INSURED _____

INSURANCE ADDRESS: _____ INSURANCE PHONE #_____

PLAN OR POLICY # _____ SUBSCRIBER ID # _____ DATE OF BIRTH _____

EMPLOYER _____ RELATION TO PATIENT _____

SECONDARY INSURANCE _____ NAME OF INSURED _____

INSURANCE ADDRESS: _____ INSURANCE PHONE #_____

PLAN OR POLICY # _____ SUBSCRIBER ID # _____ DATE OF BIRTH _____

EMPLOYER _____ RELATION TO PATIENT _____

PHARMACY OF CHOICE: _____ **Location or Address**_____

FINANCIAL RESPONSIBILITY

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 _____