GREENBRIER VALLEY UROLOGY ASSOCIATES INC.

1521 MAPLEWOOD AVENUE AT FAIRLEA RONCEVERTE, WV 24970-3026

PATIENT NUMBER_____ **PATIENT REGISTRATION** DATE_____

PATIENT INFORMATION

SOCIAL SECURITY # _____ MAILING ADDRESS _____

FIRST NAME _____ MIDDLE_____ _____

LAST NAME _____ CITY _____ STATE _____ZIP _____

GENDER _____ DATE OF BIRTH _____/_____/_____ EMAIL _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ LEGALLY SEPARATED HOME PHONE: _____

☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN WORK PHONE: _____

EMPLOYER _____ CELL PHONE: _____

(CHECK ONE) ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Part-Time Student

☐ Full-Time Student ☐ Child ☐ Housemaker ☐ Inmate ☐ Other_____

PRIMARY INSURANCE INFORMATION—PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED / CARD HOLDER'S EMPLOYER _____

POLICY # _____GROUP # _____ PHONE ( ) _____

SECONDARY INSURANCE INFORMATION—PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED / CARD HOLDER'S EMPLOYER _____

POLICY # _____ GROUP # _____ PHONE ( ) _____

TERTIARY INSURANCE INFORMATION—PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED / CARD HOLDER'S EMPLOYER _____

POLICY # _____ GROUP # _____ PHONE ( ) _____

EMERGENCY CONTACT

FIRST NAME _____ MIDDLE _____ HOME PHONE ( ) _____

LAST NAME _____ WORK PHONE ( ) _____

RELATIONSHIP _____ CELL PHONE ( ) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH _____/_____/_____

RELATIONSHIP _____ HOME PHONE ( ) _____

FIRST NAME _____ MIDDLE _____ WORK PHONE ( ) _____

LAST NAME _____ CELL PHONE ( ) _____

ADDRESS _____ EMPLOYER _____

_____ ADDRESS _____

CITY _____ STATE _____ZIP _____ CITY _____ STATE _____ ZIP _____

COMPLETE BACK SIDE

ADDITIONAL INFORMATION

ALLERGIES: (DRUG-FOOD) _____ TOBACCO ☐ YES ☐ NO

_____ LIVING WILL ☐ YES ☐ NO

DIABETIC ☐ YES ☐ NO INSULIN DEPENDANT ☐ YES ☐ NO ORGAN DONOR ☐ YES ☐ NO

BLOOD TYPE _____ MEDICAL POWER OF ATTORNEY ☐ YES ☐ NO

IF PATIENT IS A MINOR, PLEASE LIST PARENT'S NAMES

MOTHER _____ FATHER _____

RACE INFORMATION

☐ CAUCASIAN
☐ BLACK
☐ HISPANIC
☐ ASIAN
☐ NATIVE AMERICAN
☐ ASIAN PACIFIC AMERICAN
☐ PACIFIC ISLANDER
☐ SUBCONTINENT ASIAN AMERICAN
☐ ALASKAN NATIVE
☐ NATIVE HAWAIIAN
☐ BLACK NON-HISPANIC
☐ WHITE NON-HISPANIC
☐ OTHER RACE OR ETHNICITY

ETHNICITY

☐ LATINO / HISPANIC
☐ OTHER
☐ NOT REPORTED / REFUSED
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ WHITE
☐ BLACK / AFRICAN AMERICAN
☐ HAWAIIAN / PACIFIC ISLANDER
☐ TWO OR MORE RACES
☐ ASIAN

REFERRAL SOURCE

☐ REFERRING PROVIDER
☐ WALK IN
☐ FRIEND
☐ REFERRAL SERVICE
☐ YELLOW PAGES
☐ OTHER

REFERRING DOCTOR

NAME _____

ADDRESS _____

PHONE: _____

PRIMARY CARE PHYSICIAN

NAME _____

ADDRESS _____

PHONE: _____

PHARMACY OF CHOICE

NAME _____

ADDRESS _____

PHONE: _____

AUTHORIZATION

I hereby authorize you to give named patient reasonable and proper medical care by today's standards. I hereby authorize the release of medical information to insurance carriers concerning illness and treatment and I hereby assign to the doctor all payments for medical services rendered. I agree that I AM RESPONSIBLE FOR ANY AMOUNT NOT PAID BY INSURANCE. On all unpaid balances 30 days or longer from billing date, interest will be charged at 1.5% per month. Patient/Responsible Party assumes all attorney fees, collection costs and court costs relating to collection of past due balances.

____ I have received a copy of the Notice of Privacy Practices for Greenbrier Valley Urology Associates, Inc.

____ I have previously received a copy of the Notice of Privacy Practices for Greenbrier Valley Urology Associates, Inc. and do not wish to receive another one. DATE: _____

_____ _____

PATIENT/RESPONSIBLE PARTY RESPONSIBLE PARTY