Austin Urological Associates, PA.

PATIENT INFORMATION
(PLEASE PRINT)

Today's Date:____/____/____

Last Name:_____ First Name:_____ Middle:____

If under 18, Parent or Guardian Name:_____
(If Power of Attorney exists, please provide this information as well.)

Street Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

Home Phone: (____)_____Cell Phone: (_____)_____ Work Phone: (____)_____

Social Security #:_____ Occupation:_____

Employer:_____
(COMPANY) (STREET ADDRESS)

Birthdate:____/____/____ Age:____ Sex: M F Marital Status: S M D W

Spouse's Name:_____ Birthdate: ____/_____/_____

Spouse's Employer:_____ Work Phone: (___)_____

Friend or relative at different address (other than spouse):

Name:_____ Phone:_____
(**RELATIONSHIP**)

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

Referring Doctor:_____ Phone: _____

Referring Emergency Room: _____

Primary Insurance:_____ Secondary Insurance:_____

Insured's Name:_____ Relationship: _____

GENERAL OFFICE POLICIES

APPOINTMENT CANCELLATIONS: Please notify the office at least 24 hours in advance if you are not able to keep your appointment. Cancellations without advance notice are subject to a $25 fee. Cancellations for elective procedures (such as vasectomies), without 24 hours notice, will incur a $250 fee. _____Initials

REFILLS: Please allow 48 hours for the office to authorize prescription refills. The physician will authorize refills during business hours ONLY. _____Initials