

North Idaho Urology
980 W Ironwood Drive, Suite #104, Coeur d'Alene, Idaho 83814 (208) 667-0621

Patient Information: Have you ever been a patient in our office before? Y- N If yes, when _____

Referred By: _____ Date: _____

Patient Name: _____ Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number:(____) _____ Cell :(____) _____ Work:(____) _____

Social Security #: _____ Date of Birth: _____ Age: _____

Occupation: _____ Employer and Address: _____

Spouse's Name: _____ Birth Date of Spouse: _____

Emergency Contact: _____ Phone Number(____) _____ Relationship: _____

Responsible Party (If other than patient)

Name of person responsible for this account: _____ Relationship: _____

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

Occupation: _____ Employer: _____ Date of Birth: _____

Insurance Information:

Primary Insurance: _____ Subscriber: _____ Date of Birth: _____

Subscriber's Employer: _____ Policy #: _____ Group#: _____

Secondary Insurance: _____ Subscriber: _____ Date of Birth: _____

Subscriber Employer: _____ Policy #: _____ Group #: _____

Do we have permission to?

Leave a message on your answering machine at home? Yes _____ No _____

Leave a message at your place of employment? Yes _____ No _____

Discuss your medical condition with any member of your household? Yes _____ No _____

If yes, whom may be speak to? _____ Relationship: _____

"I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to North Idaho Urology for any service furnished to me by that physician. I authorize any holder of medical information about me to release to Centers of Medicare and Medicaid Services or other insurance company and it agents any information needed to determine these benefits or the benefits payable for related services. I also understand that the practices of this office may require my records being transferred by fax or computer."

Signature: _____ Today's Date: _____