ROCKY MOUNTAIN
PEDIATRIC UROLOGY

Phone: 303-839-7200
Office Manger: Deb Steinke
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PATIENT INFORMATION

Please fill out completely

PATIENT NAME _____ M ___ F___ BIRTHDATE ___/___/____
MAILING ADDRESS _____ CITY_____ ST_____ZIP_____
PHONE _____-_____-_____ CELL _____-_____-_____ EMAIL _____
CIRCLE BEST METHOD OF CONTACT OR ADD IT HERE _____

RESPONSIBLE PARTY _____
PARENTS MARITAL STATUS: MARRIED____ DIVORCED _____ SINGLE _____ WIDOWED _____

MOTHER'S NAME _____ BIRTHDATE ____/ ____/ ____
ADDRESS IF DIFFERENT FROM ABOVE _____
PHONE _____-_____-_____ CELL _____-_____-_____ WORK _____-_____-_____
OCCUPATION _____ EMPLOYER _____

FATHER'S NAME _____ BIRTHDATE ____/ ____/_____
ADDRESS IF DIFFERENT FROM ABOVE _____
PHONE _____-_____-_____ CELL _____-_____-_____ WORK _____-_____-_____
OCCUPATION _____ EMPLOYER _____

PRIMARY CARE PHYSICIAN _____ PHONE _____-_____-_____
ADDRESS _____ FAX _____-_____-_____

PRIMARY INSURANCE _____ ID# _____
GROUP # _____ PHONE _____-_____-_____
ADDRESS _____ CITY _____ ST _____ ZIP _____
PRIMARY INSURED _____ BIRTHDATE ___/___/_____ SOC SECURITY# _____

SECONDARY INSURANCE _____ ID# _____
GROUP # _____ PHONE _____
ADDRESS _____ CITY _____ ST ____ ZIP _____
PRIMARY INSURED _____ BIRTHDATE ___/____/____ SOC SECURITY# _____

EMERGENCY CONTACT please list someone other than parent of child
NAME _____ PHONE _____-_____-_____
ADDRESS _____
RELATIONSHIP TO PATIENT _____

PLEASE READ AND SIGN THE FOLLOWING:
I hereby authorize Rocky Mountain Pediatric Urology, P.C. to furnish information to insurance companies concerning my or my dependent's illness and treatment and I hereby assign Rocky Mountain Pediatric Urology, all payments for medical services rendered to my dependents or myself. I understand and agree that I am responsible for any billed amount not covered by my insurance. I understand that **COPAYMENTS ARE DUE AT THE TIME OF SERVICE.** I agree to pay a $10.00 processing fee for any co-payment not made at the time of service. I also agree, in the event my account becomes delinquent and is assigned for collection, that I will be responsible for all costs of collections, collection agency fees, attorney fees and court costs. I understand that if my insurance requires a referral for specialty services, **it is my responsibility to obtain this from my primary care physician .** If I have not obtained a referral prior to the visit with Rocky Mountain Pediatric Urology, I can postpone the appointment until the referral is obtained. Otherwise, I agree to accept full financial responsibility for any direct or ancillary (lab/radiology) charges related to services rendered.

Date _____ Parent Signature _____