Demographic Information

Children's Urology
of the Carolinas

Patient's Name _____ Sex: F M Goes by _____

Date of Birth _____ Age _____ Social Security # _____

Patient's Address _____ City_____ State_____ Zip_____

Patient's Phone #_____

Mother's (Guardian's) Name_____ DOB_____

Mother's Social Security # _____ Driver's License # _____

Home Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone # _____ E-mail _____

Mother's Employer_____ Work # _____

Father's (Guardian's) Name _____ DOB_____

Father's Social Security #_____ Driver's License # _____

Home Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone # _____ E-mail _____

Father's Employer_____ Work # _____

Other Emergency Contact (Relationship to Patient) _____

Address _____ Phone # _____

Referring Primary Physician's Name_____ Phone # _____

Practice Name_____ Address _____

Primary Insurance Company Name _____

Policyholder's Name_____ DOB_____

Policy # _____ Group # _____

Insurance Co. Claims Address _____

City _____ State _____ Zip _____ Phone # _____

Secondary Insurance Company Name _____ Policy # _____

Group _____ Policyholder's Name _____ DOB_____

We must have any insurance authorization required prior to the visit to the physician.
Assignment of Benefits to Children's Urology of the Carolinas, PLLC:
I am responsible for all charges whether or not covered by insurance including co-pay, deductible, and non-covered procedures. I am responsible for updating our office staff of any changes or additions in insurance coverage

X _____ Date_____

Print Name _____