Bay Area Urology Medical Group
Patient Information
*Please complete **ALL** sections, **back and front**, before returning this form to the receptionist.*

Last Name_____First_____Middle_____DOB_____

Address_____City_____Zip_____

Social Security No._____Marital Status_____

Home Phone_____Cell_____Email_____

Primary Care Provider_____Employed full time_____part time_____

Employer_____Work Phone_____

Ethnicity: (circle one) Hispanic/Latino not Hispanic/Lantino

Race: (circle one that best describes you)
Asian Black/African American Hispanic/Latino
Multiracial Native American Native Hawaiian/pacific islander White/Caucasian
Other unknown Prefer not to answer

Please indicate your preferred spoken language_____Interpreter Needed?_____

Emergency Contact Name_____Phone_____

Primary Insurance Co Name_____

ID No_____Group No._____

Subscriber's Name_____Relation to Self_____

Subscriber's Employer_____Subscriber's DOB_____

Subscriber's Address_____Subscriber's phone_____

Secondary Insurance Co Name_____

ID No_____Group No._____

Subscriber's Name_____Relation to Self_____

Subscriber's Employer_____Subscriber's DOB_____

Subscriber's Address_____Subscriber's phone_____

How were you referred to our office?_____

Bay Area Urology Medical Group

Patient Name:_____Patient DOB_____

Patient Social Security #_____

I hereby authorize direct payment of my insurance benefits to Bay Area Urology Medical Group for services rendered to my dependents or me by the physician or under his supervision. I understand that it is my responsibility to know my insurance benefits, whether or not the services I receive are a covered benefit, and provide referrals from my PCP if necessary.

I understand and agree that I will be responsible for any balance due that Bay Area Urology is unable to collect from my insurance carrier for whatever reason and agree to remit payment for balances billed to me within 30 days of receipt. I am responsible for any collection fees due to non-payment, including late fees of $10 per month for non-payment. I certify that I have read and agree to both the Bay Area Urology Medical Group's Patient Privacy Policies and Information for Patients.

I authorize BAUMG to release any of my or my dependent's medical information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefit. I am aware Bay Area Urology uses SCC EPIC shared Electronic Medical Record that allows both Sutter personnel and SCC Epic participating physicians and their staff access to each patient's health information. The purpose is to assist in managing their care in a coordinated way. Information in your Electronic Medical Record can be released outside the Sutter Epic system only with your express written authorization or as otherwise specifically permitted or required by law.

I authorize BAUMG to leave messages for me regarding my appointments at the phone numbers provided. I authorize them to discuss my condition and treatment with the following people that assist me with my healthcare needs.

Name	**Relationship**	**Phone Number**

I understand that if my insurance requires prior authorization for medication, I must provide this office with the necessary forms and pay a $10 fee before an authorization will be requested on my behalf.

I agree to pay a "no show" or late cancellation fee if I fail to give 24 hours notice to cancel an appointment ($25.00) or 48 hours notice to cancel a scheduled surgery or procedure($100-$200).

I understand that I will be provided with test results either by telephone or a scheduled follow up visit. If results have not been communicated to me within three days of testing, I agree to call BAUMG to obtain these results.

I hereby consent to evaluation, testing, and treatment as directed by my Bay Area Urology Physician.

Patient's Signature_____Date_____

Guardian's Signature_____Date_____
(if different from patient)
Guardian's Name_____

Patient Name_____
Date_____

Please list any prescription medications you are taking:

Name of Medication Purpose/Comments	Dose	When do you take it? (times/day)

Please circle any prescriptions above that you need refilled today.

Please list Over the Counter Medications you take, including vitamins and herbals:

_____
_____
_____

Please list any ALLERGIES you have to Medication/Food/Environment and the reaction experienced:

_____
_____
_____

Please provide your Preferred/Contracted:

Pharmacy:_____Street_____City_____

Laboratory:_____

What is the one thing that you want to make sure you have taken care of during your visit today?

Please list all other concerns you would like the doctor to address:

Please list other doctors or health providers you've recently seen or test you've had done.