UROLOGY SPECIALISTS, S.C.
CONFIDENTIAL INFORMATION
PLEASE PRINT & COMPLETE IN FULL

Today's date/date of appointment: _____________________ Account# __________________

Please indicate the doctor you are seeing today: ____J.Hoeksema, M.D. ____ L.A. Levine, M.D.

PATIENT INFORMATION

SOCIAL SECURITY: _______/_______/________
LAST NAME: ______________________________ FIRST NAME: ___________________________ MI: ____________________
ADDRESS: ____CITY: _____________________STATE: __________ZIP: ______________
HOME PHONE: (________)______________-_______________ WORK PHONE: (__________)____________-______________
DATE OF BIRTH: _______/_______/_______ SEX: (circle) F or M
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

PATIENT EMPLOYER INFORMATION

EMPLOYER: ____ OCCUPATION: ____
ADDRESS: ____CITY: _____________________ STATE: ____________ZIP: _____________
WORK PHONE: (_______)________-___________

EMERGENCY CONTACT

RELATIVE/FRIEND: ____RELATIONSHIP: _____________________________
HOME PHONE: (_______)________-__________ WORK PHONE: (_______)_______-___________

EMERGENCY CONTACT THAT DOES NOT LIVE IN HOUSEHOLD:

NAME:____ RELATIONSHIP: ____
HOME PHONE: (_______)________-__________ WORK PHONE: (_______)_______-___________

REFERRED BY

REFERRING PHYSICIAN: ____
ADDRESS: ____
CITY: ____ STATE: ____________________ ZIP: __________________________________
OFFICE PHONE: (_______) ________-___________ OFFICE FAX: (_______) ________-___________

If not referred by a physician, how did you hear about our office: (check one)

____ WEBPAGE ____ YELLOW PAGES ____ FRIEND/FAMILY ____ RADIO____INSURANCE DIRECTORY____TV ____ EMERGENY ROOM VISIT
____NEWSPAPER ____ OTHER: _________________________

PRIMARY CARE PHYSICIAN NAME (if different from above): ____
ADDRESS: ____
CITY: ____ STATE: _____________________ ZIP: __________________________________
OFFICE PHONE: (_______)________-___________ OFFICE FAX: (_______)________-___________

INSURANCE INFORMATION

RESPONSIBLE PARTY IF OTHER THAN PATIENT

(KINDLY COMPLETE IF YOU ARE NOT THE PRIMARY INSURED.)

We require a copy of your insurance card at each visit. **PLEASE NOTE:** It is the patient's responsibility to inform our office of any change in insurance coverage.

SOCIAL SECURITY OF THE POLICY HOLDER: _______/_______/________
RESPONSIBLE PARTY NAME: ____
ADDRESS: ____
CITY: __________________________________ STATE: ______________ ZIP: ___________________
HOME PHONE: (_______) ________-__________ WORK PHONE: (_______) _______-___________
DATE OF BIRTH OF THE POLICY HOLDER: _______/_______/_______ SEX: (circle) F or M RELATIONSHIP: _______________
RESPONSIBLE PARTY EMPLOYER: ____