

**ORANGE COUNTY UROLOGY ASSOCIATES, INC.**

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Patient Name: \_\_\_\_\_ Age \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:  M  F  
Last First MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Single  Married  Widowed  Divorced  E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_  Work Phone \_\_\_\_\_

**(PLEASE CHECK PREFERRED PHONE NUMBER OR E-MAIL AS PRIMARY CONTACT)**

Ethnicity ( one)  Hispanic/Latino  Non-Hispanic/Non-Latino

Race ( one)  African-American/Black  Native American/Alaskan Native  White  Other \_\_\_\_\_  
 Asian/Pacific Islander  Asian-Indian  Cambodian  Chinese  Filipino  Guamanian  Hawaiian  Japanese  
 Korean  Laotian  Samoan  Vietnamese  
 Decline to State

*\*The state law mandates reporting of certain medical diagnoses to the California Department of Health Services.*

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Drivers License# \_\_\_\_\_ S.S.# \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Referred by \_\_\_\_\_ Primary Physician \_\_\_\_\_

Pharmacy \_\_\_\_\_ Address (Street, City) \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY –If other than self or you are a minor.**

Name: \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ S.S.# \_\_\_\_\_

**MEDICAL INSURANCE (please present insurance cards for us to photocopy)**

Primary Insurance Company: \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's Relationship To Patient \_\_\_\_\_

Insured's ID# \_\_\_\_\_ Group # \_\_\_\_\_ Medicare # \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's Relationship To Patient \_\_\_\_\_

Insured's ID# \_\_\_\_\_ Group # \_\_\_\_\_ Medicare # \_\_\_\_\_

**EMERGENCY CONTACT**

Name of person not living with you \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

**Assignment of Benefit-Financial Agreement**

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date: \_\_\_\_\_ Your Signature X \_\_\_\_\_

**THANK YOU FOR YOUR CAREFUL COMPLETION OF THIS IMPORTANT FORM**