

Scioto Valley Urology, Inc.

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600 N. Pickaway Street • Suite 402 • Circleville • OH 43113
Phone: (740) 420-7882

Dear Patient:

- Please assist us by *clearly* and *correctly* completing the information.
- Please give your insurance card(s) to the receptionist for copying.

PATIENT	LAST NAME:		FIRST NAME:		MI:	TITLE:	
ADDRESS:				CITY:		STATE:	ZIP:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MARITAL STATUS: <input type="checkbox"/> SIN <input type="checkbox"/> MAR <input type="checkbox"/> SEP <input type="checkbox"/> DIV <input type="checkbox"/> WID		SOCIAL SECURITY #: _____ - _____ - _____		DATE OF BIRTH: ____ / ____ / ____	
						GUARANTOR'S DATE OF BIRTH: ____ / ____ / ____	
HOME PHONE : () -			WORK PHONE: () -			CELL PHONE: () -	
PREFERRED PHARMACY NAME:				PREFERRED PHARMACY PHONE NUMBER: () -			
REFERRING PHYSICIAN		LAST NAME:		FIRST NAME:		TITLE (ex. M.D. / D.O.)	
ADDRESS:			CITY:		STATE:	ZIP:	Phone #: () -
PRIMARY CARE PHYSICIAN		LAST NAME:		FIRST NAME:		TITLE (ex. M.D. / D.O.)	
ADDRESS:			CITY:		STATE:	ZIP:	Phone #: () -
EMERGENCY CONTACT (1st)		LAST NAME:		FIRST NAME:		RELATIONSHIP:	
HOME PHONE : () -			WORK PHONE: () -			CELL PHONE: () -	
EMERGENCY CONTACT (2nd)		LAST NAME:		FIRST NAME:		RELATIONSHIP:	
HOME PHONE : () -			WORK PHONE: () -			CELL PHONE: () -	
AUTHORIZATION	<p>THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.</p> <p>I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group, or person(s) necessary to secure payment any information needed for this or related Medicare claim. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient or his / her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations, or other services rendered under the general and specific instructions of the physicians. *I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.</p>						

DATE _____

SIGNATURE X _____

PATIENT (PARENT/GUARDIAN IF MINOR)