

**Urological Associates of Western Colorado**  
790 Wellington Avenue, Suite 202 - Grand Junction, CO 81501 - 970-243-3061

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City,State,Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ [ ]Home [ ]Work [X]Other  
Phone: \_\_\_\_\_ [ ]Home [ ]Work [X]Other

Doctor: \_\_\_\_\_  
Patient ID #: \_\_\_\_\_ Sex: [ ]M [ ]F  
**Date of Birth:** \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed  
Referring Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_

**PATIENT EMPLOYMENT** [ ]Employed [ ]Retired [ ]Unemployed [X]

Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City,State,Zip: \_\_\_\_\_

**CONTACTS**

Name, Phone & Relationship ie. Family, Pharmacy etc

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GUARANTOR** [ ]Same as Patient

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City,StateZip: \_\_\_\_\_

**EMPLOYMENT**

Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**PRIMARY INSURANCE** [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Company: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Policy Group: \_\_\_\_\_

**SECONDARY INSURANCE** [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Company: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Policy Group: \_\_\_\_\_

I authorize the release of any medical information to process insurance claims and authorize direct payment to Urological Associates of Western Colorado.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such cost as the court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation including employment verification.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_