GRANGER MEDICAL CLINIC | *Summit Urology*

Patient Information: Please Print

Name of patient _____ Age _____

Address _____
Street Apt City State Zip

Home phone _____ Email address _____

Cell phone _____ Do you get text messages? _____

Birthdate _____ SS# _____ Sex _____

Marital status: Single ___ Married ___ Widowed ___ Divorced ___ Spouse's name _____

Referring doctor _____ City _____

Family doctor _____

Race: Asian ___ Native Hawaiian ___ Other Pacific Islander ___ Black/African American ___
American Indian/Alaska Native ___ White ___

Ethnicity: Hispanic/Latino ___ Not Hispanic/Latino ___

Language preference: English ___ Spanish ___ Other _____

Emergency contacts:

Name _____ Phone number _____ Relation _____

Name _____ Phone number _____ Relation _____

Name _____ Phone number _____ Relation _____

Employer Information: Full Time ___ Part Time ___ Retired ___

Occupation _____

Employer _____ Work number _____

Responsible party and billing information: (If you are a student or a missionary, please give your home address)

Name of patient _____ Relation to patient _____

Address _____
Street Apt City State Zip

Birthdate _____ SS# _____

Employer _____ Work number _____

Insurance information (Please present your insurance card to the receptionist so they can make a copy)

Primary insurance #1:

Insurance company _____ Policy ID _____

Name of insured _____ Relation _____

Insured birthdate _____ SS# _____

Primary insurance #2:

Insurance company _____ Policy ID _____

Name of insured _____ Relation _____

Insured birthdate _____ SS# _____

I accept financial responsibility for payment of my entire account with Granger Medical Clinic/Summit Urology. *** Insurance may pay all or part of my account, but I am responsible to see that my account is paid in full. *** A finance charge of $2.00 minimum per month or 1 ½ % per month (18 % annum) will be made after 60 days following the date services are provided. *** Should the account be referred to an agency or an attorney for collection I agree to pay reasonable attorney's fees and collection expenses.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE