

Louisville Urology

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Patient Information Sheet

DEMOGRAPHICS-			
Name:	Date of Birth:	Age:	SSN #:
Marital Status: Single / Married / Divorced / Widow	Sex:	Race:	Phone #:
Street Address (Apt #):			Cell Phone #:
City:	State:		Zip Code:
Employer:		Occupation:	
Employer Address:			Work Phone:
Name of Insurance:		Name of Policyholder:	
Spouse's Name:	Date of Birth:	Age:	SSN #:
Spouse's Employer:	Employer's Address:		Work Phone:
If patient is a minor, who carries the insurance?			
Name:	Date of Birth:	Age:	SSN #:
Employer:	Employer's Address:		Work Phone:
EMERGENCY CONTACT NOT LIVING AT SAME ADDRESS:			
Name:	Relationship:	Phone:	Work Phone:
REFERRED BY: _____			
Who is your Family Doctor ? _____			
I give Drs. Uhlenhuth, Hendren, Blackford & Staff permission to release my private health care information to the following people (Name & Phone Please): _____ _____			
SIGNATURE		DATE:	
RELEASE OF INFORMATION			
I hereby authorize Eric R. Uhlenhuth M.D., Robert B. Hendren M.D. or Terrance L. Blackford M.D. to release any information and records requested with respect to any treatment rendered to me, to any insurance company, hospital, organization, employer, surgeon, pharmacist, etc., or their representatives.			
SIGNATURE:		DATE:	
SIGNATURE ON FILE:			
I hereby authorize payment directly to the provider of services and I understand that I am directly responsible for the medical, hospital or physician's charges not covered by this authorization:			
SIGNATURE:		DATE:	
NOTICE OF PRIVACY			
Sign below to acknowledge you have received a notice of our Privacy Practices.			
SIGNATURE:		DATE:	