

Please Print

Name: _____ SS# _____
Last First Middle Initial

Local Address: _____ Birthdate ____/____/____ Gender ____
Street

City State Zip

Employer Name: _____

Address: _____
Street City State Zip

Phone Number: Home: _____ Work: _____ EXT: _____

- Check all that apply: UR Student (F/T) Spouse of UR Student UR Employee - Dept: _____
 UR Student (P/T) House Officer Spouse of House Officer
 Post Doc Spouse of Post Doc UR Faculty
 Other connection to the U of R: (specify) _____

Primary Physician: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship _____
Last First

Address: _____ Phone #: work - _____
Street home - _____

City State Zip

INSURANCE INFORMATION:

Primary * :

Company Name: _____ Contract # _____

Address: _____ Subscriber: _____

Secondary:

Company Name: _____ Contract # _____

Address: _____ Subscriber: _____

* Attach a copy of your insurance ID card, or we can photocopy it for you.

Billing: Payment is expected at the time of visit.

I will pay for today's visit with (check one): cash check Visa MasterCard

I acknowledge receipt of the "Notice of Privacy Practices" enclosed with this packet.

I authorize payment of medical benefits directly to UHS. I authorize UHS to release any medical information necessary to process insurance claims. I agree to be responsible for all charges not paid by insurance.

Patient Signature _____