Asheville Urological Associates, Inc.

1 Doctors Park · Asheville, NC. · 28801
Telephone (828) 253-5314
Fax (828) 254-5216

Diplomats of the American Board of Urology
Bruce G. Armstrong, M.D.
Mark A. Yarborough, M.D., F.A.C.S.
Dane A. Weil, M.D., F.A.C.S.
Michael C. Staley, M.D., F.A.C.S.
Rick L. Bare, M.D., F.A.C.S.

PATIENT INFORMATION, MEDICAL RECORDS AUTHORIZATION & INSURANCE FILING & PAYMENT AUTHORIZATION

Patient's Name _____ Age_____ Date of Birth_____ Sex____
Last First Middle

Spouse's Name_____ If under 18, Responsible Party_____

Street Address _____
Street, P.O. Box City State Zip Code

Mailing Address_____
Street, P.O. Box City State Zip Code

Phone Number: Home_____ Business_____ Cell_____

Marital Status – (circle one) Single Married Divorced Separated

Your Social Security Number_____

Your Employer & Address_____
_____

Spouse's Employer & Address_____
_____

Name & Address of Primary Medical Insurance_____
_____

Contract No._____ Group No._____ Policy Holder's Name_____

Name & Address of Secondary Medical Insurance_____
_____

Contract No._____ Group No._____ Policy Holder's Name_____
Date of Birth_____

Name & Address of Family Physician_____
_____

Who Referred You to Us?_____

In Case of Emergency, Nearest Relative, Not Living With You_____
_____
Street, P.O. Box City State Zip Code Telephone Number

AUTHORIZATION FOR RELEASE OF INFORMATION FROM PATIENT'S MEDICAL RECORDS

I hereby authorize any Hospital, Physician or Clinic to furnish to
ASHEVILLE UROLOGICAL ASSOCIATES, INC.
1 Doctors Park, Asheville, NC 28801
any and all information concerning any sickness, operations, injury, medical history, consultations, prescriptions, or treatments, and copies of all pertinent hospital or medical records I agree that a photo static copy of this authorization shall be considered as effective as the original.

PATIENTS SIGNATURE_____
DATE_____
WITNESS_____

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1 Doctors Park, Asheville, NC 28801

AUTHORIZATION FOR INSURANCE FILING & PAYMENT

I hereby request my insurance be filed with Asheville Urological Associates, Inc.

PATIENTS NAME_____
I request that insurance payments be made directly to Asheville Urological Associates, Inc.
PATIENTS SIGNATURE_____
DATE_____
WITNESS_____