

**ASHEVILLE UROLOGICAL**

**ASSOCIATES, INC.**

1 Doctors Park, Asheville, North Carolina 28801 • (828) 253-5314

**Diplomats of the American Board of Urology**

*Bruce G. Armstrong, M.D.*

*Mark A. Yarborough, M.D., F.A.C.S.*

*Michael C. Staley, M.D., F.A.C.S.*

*Rick L. Bare, M.D., F.A.C.S.*

*J.C. Cargill, III, M.D.*

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

PATIENT'S NAME \_\_\_\_\_ Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

SPOUSE'S NAME \_\_\_\_\_ If Under 18, Responsible Party \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
Street, P.O. Box City State Zip Code

STREET ADDRESS \_\_\_\_\_  
Street, P.O. Box City State Zip Code

PHONE NUMBER: Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

MARITAL STATUS - (Circle One) Single Married Widowed Divorced Separated

YOUR SOCIAL SECURITY NUMBER \_\_\_\_\_

YOUR EMPLOYER & ADDRESS \_\_\_\_\_

SPOUSE'S EMPLOYER & ADDRESS \_\_\_\_\_

**NAME & ADDRESS OF PRIMARY**

MEDICAL INSURANCE \_\_\_\_\_

Contract No. \_\_\_\_\_ Group No. \_\_\_\_\_ Policyholder's Name \_\_\_\_\_

**NAME & ADDRESS OF SECONDARY**

MEDICAL INSURANCE \_\_\_\_\_

Contract No. \_\_\_\_\_ Group No. \_\_\_\_\_ Policyholder's Name \_\_\_\_\_

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**

**ASHEVILLE UROLOGICAL ASSOCIATES, INC.**  
1 Doctor's Park, Asheville, NC 28801

I hereby authorize any Hospital, Physician, or Clinic to furnish to

**AUTHORIZATION FOR INSURANCE FILING AND PAYMENT**

**ASHEVILLE UROLOGICAL ASSOCIATES, INC.**  
1 Doctor's Park, Asheville, NC 28801

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

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 photostatic copy of this authorization shall be considered as effective as the original.

PATIENT'S NAME

I request that insurance payments be made directly to Asheville Urological Associates, Inc.

PATIENT'S SIGNATURE \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

DATE \_\_\_\_\_

WITNESS \_\_\_\_\_

WITNESS \_\_\_\_\_