

Brett B. Abernathy, M.D., F.A.C.S.  
Richard R. Augspurger, M.D., F.A.C.S.  
Stephen R. Bales, C-ANP  
Gina A. Canon, PA-C  
Eric T. Gross, M.D.  
Richard K. Heppe, M.D.  
Elias L. Hsu, M.D.  
Marklyn J. Jones, M.D.  
Lawrence L. Karsh, M.D., F.A.C.S.  
Donald J. May, M.D.

**THE UROLOGY CENTER OF COLORADO**

2777 Mile High Stadium Circle  
Denver, CO 80211  
(303) 825-TUCC (8822) \ FAX: (303) 825-4022

Jesse N. Mills, M.D.  
Juan D. Montoya, M.D., F.A.C.S.  
Ferdinand J. Mueller, Jr., M.D.  
Alexander C. Philpott, M.D.  
David C. Ragan, M.D.  
Stephen R. Ruyle, M.D., F.A.C.S.  
Brian R. Smith, M.D.  
Carsten M. Sorensen, M.D.  
Reginald D. Westmacott, M.D.  
Lisa L. Zwiers, PA-C

**Patient Information**

Name: \_\_\_\_\_ Sex: M / F Today's Date: \_\_\_\_\_

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: M / S / D / W

Street Address: \_\_\_\_\_  
Street, PO Box City State Zip

**Contact Phone Numbers (home, work, cell):**

**Employer:**

Primary: ( ) \_\_\_\_\_ (H/W/C)

Company name: \_\_\_\_\_

Secondary: ( ) \_\_\_\_\_ (H/W/C)

Status (circle one): Full-time Part-time

Alternate: ( ) \_\_\_\_\_ (H/W/C)

Retired: Y / N Unemployed: Y / N

**Additional Information**

**Preferred Language:** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Ethnicity:** Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture/origin)  
Non Hispanic or Latino

**Race:** White / Black or African American / American Indian or Alaska Native / Native Hawaiian or Other Pacific Islander / Asian / Multiracial

**Referring Physician/Phone #:** \_\_\_\_\_ **Primary Care Physician/Phone #:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship to you:** \_\_\_\_\_ **Emergency Phone number:** \_\_\_\_\_

**Insured Information**

**Primary Insured Name:** \_\_\_\_\_ **Insured Relationship to patient:** \_\_\_\_\_  
(Are you the policy holder or is your spouse/parent) (Parent, Legal Guardian, Spouse)

**Insured Phone:** ( ) \_\_\_\_\_ **Insured Social Security Number:** \_\_\_\_\_

**Insured Date of Birth:** \_\_\_\_\_ **Insured Employer:** \_\_\_\_\_ **Status: (FT/PT):** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Insurance Claims Address:** \_\_\_\_\_

**Insurance ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Insurance ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize The Urology Center of Colorado to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance, and all collection costs should this account be assigned for collection. I accept and understand the responsibility of notifying TUCC of any requirement by my insurance company of pre-authorization prior to any hospital admission or surgical procedure, whether done in office or in hospital. I understand that it is also my responsibility to verify that a pre-authorization has been completed prior to any hospital admission or surgical procedure. I also understand if I fail to obtain a **referral**, if necessary, I will be responsible for the charges.

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_