West Alabama Urology Associates

Today's Date:

Last Name:	First Name:	M.I.	Male or Female (circle one)
Mailing Address:	Apt#	Social Security Number:	
City/State/Zip			
Primary Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Email Address:	Who referred you to us?	
Marital Status: Married Single Divorced Widow	Race (Please Circle) White Hispanic American Indian African American Decline Other		
Emergency Contact Name:	Emergency Contact Phone Number:		

RESPONSIBLE PARTY (If pt is a minor (under age of 18), the parent or guardian bringing patient in will be listed as the guarantor) Leave section blank if patient is over the age of 18

Last Name:	First Name:	
Date of Birth:	Phone #:	Relationship to Patient:
Address of Responsible Party:		
City/State/Zip:	Email Address:	

Patient Primary Insurance Carrier Name:	***Patient Secondary Insurance Carrier Name (if applicable)***
Policy Holder Name	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder SS#	Policy Holder SS#:
Relationship to Patient	Relationship to Patient

Preferred Language (Please circle) English Spanish Sign Language Other:

Request to Communicate I authorize West Alabama Urology Associates to contact me regarding clinical services by the means provided below. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I understand that information transmitted via telephone, text message, or e-mail can be intercepted and recorded by unrelated third parties. I authorize my healthcare provider to utilize this unsecured method of communication for limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual if I am unavailable at the number provided by me for the purposes shown above. I understand it is my responsibility to notify West Alabama Urology Associates should this information change. I understand that I **do not** have to provide any of the communication sources.

Complete and check all that apply.

Home Phone: _____ You may leave detailed message ☐

Cell Phone: _____ You may leave a detailed message or send text ☐

Work Phone: _____ You may leave a detailed message ☐

Email: _____ You may send a detailed message ☐

Would you like to enroll in the patient portal? ☐ Yes ☐ No

Do you give us permission to contact or leave a message with someone other than you?

If so, please provide name and phone number of this person _____

Signature of patient or patient representative: _____