

Wake Urological Associates, P.A.

Richard D. Kane, M.D.
Joseph D. Neighbors, Jr., M.D.
Philip M. Newhall, M.D.
Mark W. Jalkut, M.D.

Referred by: _____ Date: _____

Last Name: _____ First: _____ Middle: _____

Home Address _____ City _____ State _____ Zip _____

Social Security Number _____ Age _____ Date of Birth _____ Sex _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Marital Status _____ Name of spouse, parent, or significant other _____ Relationship _____

Employer (Spouse/Parent) _____ Occupation _____ Work Phone _____

Name of family Doctor _____ Pharmacy _____

Drug Allergies _____

Would your religious faith in any way interfere with your medical care? _____

Primary Ins. Co. _____ Certificate No. _____

Claims Address _____ Policyholder _____

Relationship _____

Policy Holder's SS# _____ Policy Holder's DOB: _____

Secondary Ins. Co. _____ Certificate No. _____

Claims Address _____ Policyholder _____

Relationship _____

Policy Holder's SS# _____ Policy Holder's DOB: _____

Third Ins. Co. _____ Certificate No. _____

Claims Address _____ Policyholder _____

Relationship _____

* It is not our policy to file insurance claims for office visits with insurance companies with whom we do not have a contract.

** It is the responsibility of the patient to notify this office of pre-admission certification and/or second opinion requirements of their insurance company at the time of scheduling hospital admissions or surgery.

I hereby authorize the release of any medical information pertinent to my care to my referring physician/family physician and insurance companies and accept responsibility for payment of all medical/surgical fees and authorize payment of insurance benefits to WAKE UROLOGICAL ASSOCIATES, P.A., except when the amount due has been paid in full by me.

Signed: _____