West Shore Urology, P.L.C.

1301 Mercy Drive • Muskegon, MI 49444 • 231.739.9492 • www.westshoreurology.com

PATIENT INFORMATION

PLEASE FILL IN ALL THE BLANKS -- IF NONE, WRITE "NONE". PLEASE USE BLUE OR BLACK INK. NO PENCIL. BE SURE TO ALSO SIGN AND DATE.

PATIENT ACCOUNT NUMBER _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY NO. _____

STREET ADDRESS _____ APT/PO BOX/LOT NO. _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____ CELL PHONE _____

HAVE YOU EVER BEEN SEEN BY THIS OFFICE UNDER ANY OTHER NAME? ❑ YES ❑ NO _____ PREVIOUS NAME

The Federal Government requires physician groups to collect certain information. This information is about your Race and Ethnic background. You are **not required** to provide this information and you **may decline** to answer.

RACE

❑ DECLINE
❑ AFRICAN AMERICAN
❑ ASIAN
❑ HISPANIC/LATINO
❑ NATIVE AMERICAN
❑ PACIFIC INLANDER
❑ OTHER
❑ WHITE/CAUCASIAN

ETHNICITY

❑ DECLINE
❑ HISPANIC or LATINO
❑ NOT HISPANIC or LATINO

PREFERRED LANGUAGE

❑ DECLINE
❑ ENGLISH
❑ FRENCH
❑ GERMAN
❑ JAPANESE
❑ KOREAN
❑ OTHER
❑ RUSSIAN
❑ SPANISH

EMERGENCY CONTACT: _____ NAME _____ PHONE _____ RELATIONSHIP TO PATIENT

REFERRING DOCTOR _____ FAMILY DOCTOR _____

PHARMACY NAME _____ PHONE _____ LOCATION _____

MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

PATIENT EMPLOYED ❑ FULL TIME ❑ PART TIME ❑ NOT EMPLOYED ❑ RETIRED ❑ SELF EMPLOYED ❑ DISABLED

PATIENT'S EMPLOYER _____ EMPLOYER'S STREET ADDRESS _____

EMPLOYER'S CITY/STATE/ZIP _____ PHONE _____

YOU WILL BE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE OR BALANCE AT THE END OF EACH VISIT.

SPOUSE'S NAME _____ BIRTH DATE _____ SOCIAL SECURITY NO. _____

SPOUSE EMPLOYED? ❑ FULL TIME ❑ PART TIME ❑ NOT EMPLOYED ❑ RETIRED ❑ SELF EMPLOYED ❑ DISABLED

SPOUSE'S EMPLOYER _____ EMPLOYER STREET ADDRESS _____

EMPLOYER'S CITY/STATE/ZIP _____ PHONE _____

NextMD®

NextMD® is a patient portal for patients to correspond with our office online. Patients are able to send non-emergency questions to their providers; request appointments, medication refills and copies of medical records; view their statements and pay their bills online in the comfort of their own home at any time of day.

*Would you like to sign up for **NextMD®**?* ❑ *yes* ❑ *decline*

If yes, please provide e-mail address: _____

PLEASE SEE REVERSE SIDE

PATIENT NAME: _____

West Shore Urology, P.L.C.

DATE OF BIRTH: _____

ARE YOU ENROLLED IN HOSPICE? ❑ YES ❑ NO IF YES, WHAT COUNTY_____

ARE YOU A RESIDENT OF A SKILLED NURSING FACILITY? ❑ YES ❑ NO NAME _____

WORKERS COMPENSATION: MUST HAVE LETTER OF AUTHORIZATION FROM EMPLOYER.

IS THIS WORK RELATED? ❑ YES ❑ NO DATE OF INJURY_____

COMPENSATION CARRIER NAME & ADDRESS _____

IS THIS A RESULT OF AN AUTOMOBILE ACCIDENT? ❑ YES ❑ NO IF YES, PLEASE HAVE AUTO INSURANCE INFORMATION AVAILABLE.

How did you hear about our office? ❑ FAMILY PHYSICIAN ❑ FAMILY / FRIEND ❑ WEB SITE

❑ PHONE BOOK, If so, which one? ❑ VERIZON ❑ YELLOW BOOK ❑ SBC

IF A MINOR, PLEASE COMPLETE:

FATHER'S NAME _____ BIRTH DATE_____

SOCIAL SECURITY NO._____ HOME PHONE_____ CELL PHONE_____

HOME ADDRESS_____ CITY/STATE/ZIP_____

FATHER'S EMPLOYER_____ EMPLOYER'S STREET ADDRESS_____

EMPLOYER'S CITY/STATE/ZIP_____ PHONE_____

MOTHER'S NAME _____ BIRTH DATE_____

SOCIAL SECURITY NO._____ HOME PHONE_____ CELL PHONE_____

HOME ADDRESS_____ CITY/STATE/ZIP _____

MOTHER'S EMPLOYER_____ EMPLOYER STREET ADDRESS_____

EMPLOYER'S CITY/STATE/ZIP_____ PHONE_____