Urology Associates of Lebanon, PA, P.C.

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Please note…the following information is very important to your health and treatment. Please take the time to fully complete this important information. Thank you in advance for your assistance!

Emergency Contact (Name & Phone #) ___________________________________

Emergency Contact (Name & Phone #) ___________________________________

Date _________________________________

Name (First/M.I./Last) ____

Date of Birth (Month/day/year) __________________________________Age_________________________

Address____

City/State/Zip Code ____

Home Phone #__________________ Cell Phone # _________________ Work Phone # _________________

Gender (Please Circle): Male   Female

Race (Please Circle): White   Black/African American   Asian

American Indian/Alaska Native   Native Hawaiian/Other Pacific Islander   Other

Ethnicity (Please Circle): Spanish/Hispanic Origin   Not of Spanish/Hispanic Origin

Decline this information

What is your primary language? ____

Social Security Number ____

Marital Status (please circle)   Single   Married   Separated   Divorced   Widowed

Spouse's Name _______________________________________

Family Physician ___________________________ Referring Physician ____________________________

Employer ____

Reason for Visit ____

May we call your home phone number and leave messages regarding your care here?   YES   NO

May we call your cell phone number and leave messages regarding your care here?   YES   NO

May we request information from your pharmacy(s) regarding your medications (current and history)?   YES   NO

What pharmacy do you use? ____

Patient Initials ______________________