EFFINGHAM UROLOGY ASSOCIATES, SC
414 W VIRGINIA AVE
EFFINGHAM, IL 62401
PHONE: 217-342-9738 **FAX: 217-342-9806**

NEW PATIENT FORM

Complete and return this form to the office with a copy of medical records that pertain to the reason you are requesting an appointment. Forms can be faxed to 217-342-9806, dropped off at the office, mailed, or emailed to urology@consolidated.net. Forms returned without medical records will not be reviewed and no appointment will be given. If you have not been treated for this diagnosis, see your primary care physician before completing this form.

DEMOGRAPHICS

Patient Name: ______________________________ **DOB:** ____________________________

SSN: ___________________________________

Address: ____

City: ___________________________ **State:** ____________________ **Zip:** _____________________

Phone number: __________________________________ **Alternate number:** ________________________

INSURANCE

☐ **I have reviewed the insurances accepted by Effingham Urology Associates.**

☐ **I have read the policy on the website that pertains to self-pay patients and patient has been informed of amount due at first appointment.**

☐ **Insurance card attached.**

MEDICAL

Reason for appointment:_______________________________ **Duration:**_____________________

Referred by: ____

PROVIDER

☐ First Available ☐ Dr. Nayak ONLY ☐ Angie Yocom ONLY ☐ Hank Habing ONLY

APPOINTMENT PREFERENCE

☐ First Available ☐ Mornings ONLY ☐ Afternoon ONLY ☐ Specific day _______________

We will try to accommodate your request; however not all providers are here at all times.

APPOINTMENT STATUS

☐ Patient Approved ☐ Patient Not Approved

☐ Appointment made for: ____________________ at __________________ with _________________________.
(DATE) (TIME) (PROVIDER)

THE REFERRING PROVIDER MUST NOTIFY THE PATIENT OF THE APPOINTMENT!!!