Dr. Mansel K. Kevwitch, M.D., F.A.C.S.
Pacific Rim Urology 360-428-7777

1730 East Division Street
Mount Vernon, WA 98274

Patient Name_____ Phone:_____

Responsible Party/ Relationship_____ Phone:_____

Patient Address:_____

E-mail Address:_____

Responsible Party Address:_____

Sex: M F Marital Status: Single Married Separated Divorced Widowed

Age:_____Date of Birth:_____ Social Security #_____

Race: White Black Asian Pacific Islander American Indian Mexican American Not Provided

Ethnicity: Hispanic Not Hispanic Not Provided **Language spoken**: English Spanish Russian Other

Name of Spouse_____Business Phone:_____

Emergency Contact:_____Phone Number:_____

Referring Physician:_____ Primary Care Physician:_____

Pharmacy Name:_____ City_____ Phone _____

Primary Insurance:_____ID #_____

Subscriber:_____Date of Birth:_____ Group #_____

Secondary Insurance:_____ID #_____

Subscriber:_____Date of Birth: _____Group #_____

I request that payment of authorized insurance benefits be made on my behalf to Pacific Rim Urology. I authorize any holder of medical or other information about me to be released to my insurance company and its agents if information is needed to determine these benefits or benefits for related services. I also accept responsibility for services rendered, regardless of third party involvement I consent for medical treatment and have verified the insurance listed on this slip.

I give my consent for my physician to view and maintain a copy of my Sure Scripts prescription history as part of my clinical medical record. I understand that this information will remain confidential and will not be transferred to outside entities without my written consent. I also have received and understand the policies outlined in HIPAA summary "Notice of Privacy Practices."

Signature: _____Date: _____

Guardian Signature: _____Date:_____
(If patient is under the age of 18)

06/25/2014 updated