Barnes Urology
William F. Barnes, MD PC

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Phone: (405)644-5175 Fax: (405)644-5176

Patient Name: _____**Today's Date:** _____
First **MI** **Last**

SS #: _____ **Date of Birth:** _____/_____/_____ **Age:** _____ **Sex:** M _____ F _____

Home Address _____ **Apt #** _____

City: _____ **State:** _____ **Zip Code:** _____

Cell #: _____ **Home #:** _____ **Work #:** _____

Please circle the best method for contacting you: **CELL** **HOME** **WORK**

May we leave a message on your Cell phone or Answering Machine? **Yes** **No**
(medical information, appointment dates and times, labs, results of labs or scans, etc.)

Provide your Email address for the Patient Portal:_____
(Patient Portal will allow you to view your medical records on-line. You will be the only one to have access to your records)

Employer: _____ or **Retired** **Student** **Disabled** **Unemployed**

Responsible Party name: _____
If Patient is Minor **First** **MI** **Last**

Primary Insurance Company _____ **Policy Number:** _____

Policy Holder Name _____**Date of Birth** ___/____/____ **SSN #:** _____

Employer Name/ Address / Phone #: _____

Secondary Insurance Company _____ **Policy Number:** _____

Policy Holder Name _____**Date of Birth** ___/____/____ **SSN #:** _____

Employer Name/ Address / Phone #: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION

Whom May we thank for referring you to our office? _____

Name and Number of your Primary Care Physician: _____

Name and Number of Other Physicians _____

Name, Number and Location of your Pharmacy: _____

Signature _____ **Date** _____

THIS FORM MUST BE SIGNED AND DATED BY PATIENT OR LEGAL GUARDIAN OF A MINOR