UROLOGY CENTER OF SOUTH FLORIDA,P.A.

MM#: _____ APPT. DATE: _____

TODAY'S DATE: _____

DOCTOR: G S B P

Patient Information

NAME: _____ SEX: _____ REFERRED BY:_____

SOCIAL SEC. #: _____ BIRTH DATE: _____ MARITAL STATUS (SMWD): _____

HOME PHONE #: _____ CELL PHONE #: _____ AGE: _____

LOCAL STREET ADDRESS: _____ APT. #: _____

CITY: _____ ST: _____ ZIP: _____

EMAIL ADDRESS: _____

OUT OF STATE STREET ADDRESS: _____ APT. #: _____

CITY: _____ ST: _____ ZIP: _____

DRIVERS LICENSE #: _____ DRIVERS LICENSE STATE: _____

EMPLOYER/SCHOOL:_____ TITLE: _____ PHONE: _____

STREET ADDRESS: _____ CITY: _____ST: _____ ZIP:_____

SPOUSE:_____ AGE: _____ BIRTH DATE: _____

SPOUSE EMPLOYER:_____ TITLE: _____ PHONE: _____

STREET ADDRESS: _____ CITY: _____ST: _____ ZIP:_____

PRIMARY CARE PHYSICIAN: _____ DO YOU HAVE A LIVING WILL? ❑ YES ❑ NO

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

STREET ADDRESS: _____ CITY: _____ST: _____ ZIP:_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

FATHER'S NAME:_____

ADDRESS: _____

CITY:_____ ST: _____ ZIP: _____

FATHER'S SS#: _____ DATE OF BIRTH _____

EMPLOYED BY: _____

PHONE: _____

MOTHER'S NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

MOTHER'S SS#: _____ DATE OF BIRTH _____

EMPLOYED BY:_____

PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE #: _____

I.D. #: _____

GROUP NAME OR #: _____

INSURED'S LAST NAME: _____

FIRST NAME: _____

IS THIS AN EMPLOYER PLAN: _____

INSURED'S S.S #: _____

INSURED'S DOB: _____

RELATIONSHIP TO INSURED: _____
(SELF-HUSBAND-WIFE-CHILD-OTHER)

SECONDARY INSURANCE INFORMATION

INSURANCE CO: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE #: _____

I.D. #: _____

GROUP NAME OR #: _____

INSURED'S LAST NAME: _____

FIRST NAME: _____

IS THIS AN EMPLOYER PLAN: _____

INSURED'S S.S #: _____

INSURED'S DOB: _____

RELATIONSHIP TO INSURED: _____
(SELF-HUSBAND-WIFE-CHILD-OTHER)

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make payments directly to my doctor and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my doctor. i hereby authorize my doctor to release any information required in the course of examination and treatment.

To avoid misunderstanding regarding medical insurance we wish our patients to know all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare necessary forms to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in the instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you.

Signed _____ Date _____

MEDICARE

Name of Beneficiary_____ Medicare #_____

I request that payment of authorized medicare benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services.

Signed _____ Date _____

MEDIGAP

Name of Beneficiary_____ Medicare #_____

I request that payment of authorized Medigap benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the above mentioned insurance carrier any information needed to determine these benefits or benefits payable for related services.

Signed _____ Date _____

I understand that any account balance that is not paid may be sent to a collection agency. Should my delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Signed _____ Date _____