UROLOGIC SPECIALTIES P.A.
PATIENT REGISTRATION

NAME _____ S.S.#_____

STREET ADDRESS_____ DATE OF BIRTH_____ MARITAL STATUS S M W SEP D

CITY_____ STATE_____ ZIP_____

TELEPHONE (HOME)_____ OFFICE_____

REFERRED BY_____ FAMILY PHYSICIAN_____

SPOUSE'S NAME_____

SPOUSE'S EMPLOYER/ADDRESS_____

EMERGENCY CONTACT_____ TEL #_____ RELATIONSHIP_____

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME_____ TEL#_____

EMPLOYER STREET ADDRESS_____ CITY/STATE_____ ZIP_____

PATIENT'S OCCUPATION _____

INSURED PERSON (IF NOT PATIENT)

NAME_____ TEL #_____

STREET ADDRESS_____ CITY/STATE_____ ZIP_____

RELATIONSHIP TO PATIENT_____

INSURANCE

PRIMARY INSURANCE COMPANY NAME_____

ID#_____ GROUP #_____ Tel #_____

SECONDARY INSURANCE COMPANY NAME_____

ID#_____ GROUP #_____ Tel #_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

May we call your home with messages, or leave test results with a family member, or on your answering machine

__Yes __No

DATE ____/____/____SIGNATURE _____

MEDICARE & MEDICAID:

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administrator or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.
I request that payment under the medical insurance program be made either to me or to Urologic Specialties, P.A. on any bills or services furnished me by Urologic Specialties, P.A. during the next 12-month period.

ALL OTHER INSURANCE:

I hereby authorize Urologic Specialties, P.A. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services for the next
12-month period.
I authorize Urologic Specialties, P.A. to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.
I understand I am financially responsible to Urologic Specialties, P.A. for any balance not covered by this authorization including deductibles

I authorize Urologic Specialties, P.A. to use photography as a means of identification and for medical purposes. The actual photographs will not be released to any person, agency or institution unless I specifically authorize it.

DATE ____/____/____SIGNATURE _____