**PATIENT INFORMATION FORM**

THIS INFORMATION IS CONFIDENTIAL

TODAYS DATE (PLEASE PRINT CLEARLY)

PATIENT’S NAME BIRTHDATE

First Middle Last

SOCIAL SECURITY # MARITAL STATUS ADDRESS APT # CITY ST ZIP HOME PHONE ( ) PERMANENT HOME PHONE ( ) PERMANENT ADDRESS APT # CITY ST ZIP EMPLOYER WORK PHONE ( ) ADDRESS OCCUPATION NAME OF SPOUSE (OR PARENT) BIRTHDATE ADDRESS SOCIAL SECURITY # OF SPOUSE (OR PARENT) PHONE ( ) SPOUSE’S EMPLOYER PHONE ( )

NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU, ADDRESS & PHONE NUMBER

REASON FOR VISIT REFERRED BY

DATE OF LAST GENERAL PHYSICAL EXAM SMOKER YES NO

(MONTH/YEAR) (CIRCLE)

LIST ANY ALLERGIES YOU HAVE

**PRIMARY INSURANCE NAME & ADDRESS SECONDARY INSURANCE NAME & ADDRESS**

INSURED NAME INSURED NAME INS. THRU EMPLOYER YES NO INS. THRU EMPLOYER YES NO

GROUP # GROUP # POLICY # POLICY #

I.D. # I.D. #

MEDICARE PATIENTS ONLY

**LIFETIME AUTHORIZATION**

**Medicare Certification**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance.

Signed Date

If signed by other than beneficiary, state relationship & reason patient was unable to sign:

**FINANCIAL**

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. I also understand that if I am “out of network” with my insurance coverage, benefits are still due and payable to Florida Urology, PA.

(Patient) (Date)

**ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION**

I authorize payment of medical benefits to the names provided for professional services rendered and the release of any medical information necessary to process this claim.

Furthermore, I hereby instruct and direct that Insurance Company to pay by check made out and mailed to: Florida Urology, 431 West Oak Street, Kissimmee, Florida

34741. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, and balance of said professional service charges over and above this insurance payment.

I also hereby ask and authorize Florida Urology to complain to the insurance commissioner on my behalf when Florida

Urology deems it necessary.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Policy holder/Claimant Date

Witness Date

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**Receipt of Notice of pRivacy pRactices**

**WRitteN ackNoWledgemeNt foRm**

I, , have received a copy of FLORIDA UROLOGY PA’s Notice of Privacy Practices.

Patient Name

Signature of Patient Date

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