

A. PATIENT INFORMATIONName _____
(Last) (First) (M.I.)Address _____
(Street) (City) (State) (Zip)

Home phone _____ Cell phone _____ Work Phone _____

Sex: M F DOB: _____ Age: _____ SS#: _____
(optional - Medicaid patients must fill out)

Marital Status: S M W D

Occupation _____ Employer _____

Referring physician _____ Family Physician _____

Physicians seen regularly _____

Have you ever seen a urologist before? Y N If so who? _____

Pharmacy Name/Location _____ Phone (____) _____

Emergency Contact Information:

Name _____ Relationship _____ Phone (____) _____

B. REGARDING THE INSURED INFORMATION OR POLICY HOLDER - RESPONSIBLE PARTY INFORMATION OF DEPENDENTName _____
(Last) (First) (M.I.)Address _____
(Street) (City) (State) (Zip)

Home phone _____ Cell phone _____ Work Phone _____

DOB: _____ SS#: _____

C. INSURANCE INFORMATION - We will need to copy your insurance cards

Primary Insurance _____ Insurance ID# _____ Group _____

Policy Holder _____ Policy Holder's DOB _____

Policy Holder's SS# _____ Relationship to Patient _____

Employer _____ Occupation _____

Secondary Insurance _____ Insurance ID# _____ Group _____

Policy Holder _____ Policy Holder's DOB _____

Policy Holder's SS# _____ Relationship to Patient _____

Employer _____ Occupation _____

PLEASE NOTIFY RECEPTIONIST IF THIS IS WORKERS COMPENSATION OR NO FAULT

ASSOCIATED MEDICAL PROFESSIONALS

AUTHORIZATION FOR RELEASE OF INFORMATION AND DIRECT PAYMENT

I hereby authorize Associated Medical Professionals to release my medical information necessary for filing claims for service carriers liable for such payments. I hereby authorize the insurance carriers to make payment of benefits directly to Associated Medical Professionals to act as my agent to help me secure payment from my insurance company. I understand that I am responsible for my bill.

Signature: _____ Date: _____

Patient Name (PLEASE PRINT): _____

MEDICARE BENEFITS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information to release to the Social Security Administration or its carriers any information required to process my medical claim. I request that payment be made indefinitely to Associated Medical Professionals for services provided under the medical insurance program.

Signature: _____ Date: _____

Patient Name (PLEASE PRINT): _____

YOU ARE RESPONSIBLE FOR ANY COPAYMENTS (AT TIME OF SERVICE), DEDUCTIBLES OR UNCOVERED SERVICES. PAYMENT IS EXPECTED FOR SERVICES AT THE TIME THEY ARE RENDERED. THIS OFFICE WILL SUBMIT INSURANCE CLAIMS FOR CARRIERS ONLY.

IF THE PATIENT IS A MEMBER OF ANY INSURANCE COMPANY REQUIRING A REFERRAL, SUCH AS HEALTHSOURCE, HMO CNY, A VALID REFERRAL MUST BE ON FILE WITH THIS OFFICE AT THE TIME SERVICES ARE RENDERED OR THE PATIENT WILL BE RESPONSIBLE FOR THE BILL.

THE PATIENT AGREES TO PAY ALL COLLECTION CHARGES IF IT IS NECESSARY TO PURSUE PAYMENT OF THE ACCOUNT THROUGH A COLLECTION AGENCY.

PATIENT OR PARENT'S SIGNATURE _____ DATE _____

Patient Name (PLEASE PRINT): _____