PATIENT INFORMATION FORM

COMPLETED BY PATIENT

A. PATIENT INFORMATION

Today's Date: ____________

Last Name ____________ First Name ____________ Middle Initial(s) ____________

Street ____________ City ____________ State ____________ Zip ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

E-Mail Address ____________

☐ Male ☐ Female
Sex ____________ Date of Birth ___ / ___ / ___ Age ____ Social Security # ___ - ___ - ___ (**Required for Medicaid,** Otherwise Optional)

☐ Single ☐ Married ☐ Widowed ☐ Divorced
Marital Status ____________ Language(s) Spoken ____________

☐ Caucasian ☐ African American ☐ Asian American ☐ Indian ☐ Native Hawaiian ☐ Decline to Answer
Race

☐ Spanish/Hispanic Origin ☐ Not Spanish/Hispanic Origin ☐ Decline to Answer
Ethnicity

Occupation ____________ Employer ____________

Referring Physician ____________ Family Physician ____________

Physician(s) Seen Regularly ____________

☐ Yes ☐ No
Have you ever seen a Urologist before? ____________ If Yes, whom? ____________

Pharmacies Used Regularly (Mail Order & Local Location, include phone numbers) ____________

Emergency Contact Person: ____________ Relationship ____________ Phone Number ____________

B. INSURED'S INFORMATION OR DEPENDENT'S RESPONSIBLE PARTY POLICY-HOLDER INFORMATION

Last Name ____________ First Name ____________ Middle Initial(s) ____________

Street ____________ City ____________ State ____________ Zip ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________ Date of Birth ____________ Social Security # ____________

PLEASE NOTIFY RECEPTIONIST IF THIS IS A WORKERS COMPENSATION OR NO FAULT ISSUE

C O M P L E T E D B Y P A T I E N T

C. INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD(S) TO BE COPIED)

Primary Insurance | Insurance ID# | Group

Policy Holder | Policy Holder's Date of Birth

Policy Holder's SSN | Relationship to Patient

Employer | Occupation

Secondary Insurance | Insurance ID# | Group

Policy Holder | Policy Holder's Date of Birth

Policy Holder's SSN | Relationship to Patient

Employer | Occupation

YOUR 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

Print Name

Date

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

Print Name

Date

PAYMENT TERMS

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.

Signature

Print Name

Date

PLEASE NOTIFY RECEPTIONIST IF THIS IS A WORKERS COMPENSATION OR NO FAULT ISSUE