ADVANCED UROLOGY INSTITUTE

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PATIENT INFORMATION FORM

TODAY'S DATE _____

NAME _____ HOME PHONE _____ CELL/OTHER PHONE _____

Primary Address _____ CITY _____ STATE/ZIP _____

Secondary Address _____ CITY _____ STATE/ZIP _____
(If Applicable)

Dates residing at SECONDARY ADDRESS _____ PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ MALE _____ FEMALE _____

MARITAL STATUS _____ SPOUSE/NEAREST RELATIVE _____ CONTACT # _____

EMERGENCY CONTACT OTHER THAN SPOUSE/RELATIVE _____ CONTACT # _____

YOUR RACE: Please check one: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER _____

YOUR ETHNICITY: Please check one: ☐ HISPANIC / LATINO ☐ NON-HISPANIC/NON LATINO ☐ OTHER _____

YOUR PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ RUSSIAN ☐ OTHER _____

YOUR EMAIL ADDRESS: _____ Preferred Methos of Contact: _____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ DISABLED ☐ RETIRED ☐ STUDENT ☐ UNEMPLOYED ☐ OTHER _____

EMPLOYER _____ WORK TELEPHONE NUMBER _____

How do you plan to pay for your medical treatment with us? ☐ Self pay (Cash/Check/Visa/MC) ☐ Medicare ☐ Medicare Supplement
☐ Medicare HMO ☐ Private Insurance (HMO, PPO, Indemnity) ☐ Worker's Compensation

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

POLICY NUMBER _____ POLICY NUMBER _____

GROUP NUMBER _____ GROUP NUMBER _____

Policyholder Name _____ Policyholder Name _____

Policyholder DOB & SS# _____ Policyholder DOB & SS# _____

Relationship to Policyholder _____ Relationship to Policyholder _____

Primary care physician's name and phone number: _____

Pharmacy name and phone number _____

PLEASE READ AND SIGN:

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I AGREE TO PAY ALL AMOUNTS NOT PAID BY MY INSURANCE CARRIER ACCORDING TO MY POLICY PROVISIONS AND THE PROVIDER CONTRACT. IN THE EVENT OF A DISPUTED PAYMENT, IT IS MY RESPONSIBILITY TO PAY FOR THE CHARGES AND DISPUTE THE PAYMENT WITH MY INSURANCE CARRIER. IT IS ALSO MY RESPONSIBILITY TO RECEIVE AUTHORIZATION/REFERRALS FOR ANY OFFICE VISITS TO ADVANCED UROLOGY INSTITUTE.

I HEREBY AUTHORIZE MY PHYSICIAN TO ACCESS MY PRESCRIPTION HISTORY IN ORDER TO DETERMINE THE CORRECT FORMULARY IN ACCORDANCE WITH MY HEALTH INSURANCE BENEFITS.

PATIENT/GUARDIAN SIGNATURE _____ HOW DID YOU HEAR ABOUT US? _____