UROLOGIC PHYSICIANS AND SURGEONS, P.A.

a division of UGF

Diplomates, American Board of Urology

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DATE:

NAME	SEX: M ____ F ____	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY APT #	CITY AND STATE		ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		MOBILE PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
SPOUSE'S / PARTNER'S NAME	NUMBER OF CHILDREN AND AGES			MARITAL STATUS S M DP W D
SPOUSE'S / PARTNER'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
WHO CAN WE CALL IN AN EMERGENCY, OTHER THAN YOUR HOME PHONE:	E-MAIL:			

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE

GOVERNMENT MANDATED QUESTIONS:

RACE ❐ Caucasian ❐ Afro-American ❐ Hispanic ❐ Asian ❐ American Indian ❐ Alaskan Native ❐ Pacific Islander Other_____ ❐ Declined

PRIMARY LANGUAGE ❐ English ❐ Spanish ❐ Other _____ ❐ Declined

ETHNICITY (CHECK APPROPRIATE)

❐ NO, Not Hispanic, Latino, or Spanish Origin ❐ YES, Mexican, Mexican-American or Chicano Origin

❐ YES, Puerto Rican Origin ❐ YES, Cuban Origin ❐ YES, another Hispanic, Latino or Spanish Origin ❐ Declined

NORTHERN ADDRESS:

Street: _____ City_____ St _____ Zip _____

Phone _____

Referred by: _____ PCP _____

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring health care provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurances and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged $35. If we determine your account should be placed with an outside collection agent or an attorney, you will be assessed an additional 30% of the balance due.

Signed _____ Date _____