UROLOGIC PHYSICIANS AND SURGEONS, P.A.

a division of UGF Diplomates,
American Board of Urology

Murray G. Goldberg, M.D.
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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.
PATIENTS EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?			MOBILE PHONE NO.
EMPLOYER 'S STREET ADDRESS	CITY AND STATE				ZIP CODE
SPOUSE'S/PARTNERS NAME	NUMBER OF CHILDREN AND AGES				MARITAL STATUS: S / M / DP / W / D
SPOUSE'S/PARTNERS EMPLOYERS	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 APPROPRTATE)

☐ 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 ____________________________