Urology Specialists of West Florida

UROLOGY SPECIALISTS OF WEST FLORIDA

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 ☐GREEK ☐ OTHER__________________________

YOUR EMAIL ADDRESS: ____________________________ Preferred Method 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) ☐ OTHER

PRIMARY CARE PHYSICIAN (FIRST AND LAST NAME) :____

PHARMACY NAME AND ADDRESS: ____

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______________________

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 UROLOGY SPECIALISTS OF WEST FLORIDA LLP. IF ANY ACCOUNTS ARE SENT TO COLLECTIONS I WILL PAY A COLLECTION FEE OF $75.

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?_______________