PATIENT INFORMATION

Note: Payment is expected at the time services are rendered

Highlighted Areas Required

Dr. ______________________

Date ______________________

(Please Print Clearly)

Patient's Full Name ______________________

Name You Prefer To Be Called ______________________ Email ______________________

Address ______________________ Home Phone ( ) ______________________

City, Zip ______________________ Cell Phone ( ) ______________________

Date of Birth ______________________ Sex: ❑Male ❑Female Marital Status: ❑M ❑W ❑S ❑D

Patient's Social Security # ______________________ Occupation ______________________

Patient's Employer ______________________ Work Phone ( ) ______________________

Referring Physician ______________________ Family Physician ______________________

Responsible Party ______________________ Relationship to Patient ______________________

(If other than patient or a minor)

Patient's Pharmacy ______________________

Spouse/Parent of Minor Name ______________________ Date of Birth ______________________

Employer ______________________ Occupation ______________________

Work Phone ______________________ Social Security # ______________________

Person to contact not living at same address ______________________

Relationship to Patient ______________________ Phone ( ) ______________________

PRIMARY INSURANCE

Insurance Company ______________________ Identification Number ______________________

Group Number ______________________ Date of Birth ______________________

Policyholder ______________________ Relationship to Patient ______________________

SECONDARY INSURANCE

Insurance Company ______________________ Identification Number ______________________

Group Number ______________________ Date of Birth ______________________

Policyholder ______________________ Relationship to Patient ______________________

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized MEDICARE BENEFITS and any other medical and/or surgical benefits, to include MAJOR MEDICAL BENEFITS to which I am entitled to be made either to me or on my behalf to VIEWMONT UROLOGY CLINIC, P.A., for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR "ALL" CHARGES WHETHER OR NOT PAID BY SAID INSURANCE, I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Date ______________________

Signature ______________________

Witness ______________________

F-008

Please return completed form to Check-In Area as soon as possible.