

PATIENT INFORMATION: SS#: _____

Last name: _____ First name: _____ MI: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone# _____ Cell# _____

Age: _____ DOB: _____ Male: ___ Female: ___ Marital Status: _____

Employer: _____ Occupation: _____

Work # _____ Emergency Contact: _____ Phone # _____

Patient referral information: Your insurance company and Dr. Robinson require this information. Dr. Matthew Robinson utilizes this information to send information about your care to your Referring and primary care physician (if appropriate).

Referring M.D. : _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Insurance Information: Please complete this section if the patient is not the primary cardholder for either the primary or secondary insurance. This information is required by the insurance company for identification of policyholder and correct billing.

Primary Cardholders Name: _____

Primary Cardholders DOB: _____ Primary Cardholders SS#: _____

Assignment and Release

I, the undersigned have insurance with _____ and assign directly to the Urology Place all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to The Urology Place for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and patient is responsible only for deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Signature _____