

NEW PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Local Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: () _____ Daytime Telephone: () _____

If a patient is a MINOR, patient's or guardian's

Name: _____ Relationship: _____

Language(s) Spoken: _____

Sex: () Male () Female Marital Status: () Single () Divorced () Married () Other

SS#: _____ / _____ / _____

Employer: _____ Telephone: () _____

Address: _____ Occupation: _____

Primary Care Physician: _____ Referred By: _____

Next of Kin: _____ Relationship: _____

Home Telephone: () _____ Work Telephone: () _____

Insurance Company: _____

Your Pharmacy of Choice: _____ Telephone: () _____

Please Complete Second Page, Thank You



MEDICAL AUTHORIZATION AND LIFETIME PATIENT SIGNATURE

I request that payment of authorized insurance benefits either to me or on my behalf be made payable to UROLOGICAL CONSULTANTS OF FLORIDA, P.A. for any services furnished me by that doctor. 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 or the benefits payable for related services. I also understand that if my insurance company does not provide payment to UROLOGICAL CONSULTANTS OF FLORIDA, P.A., that will be billed and I agree to pay for said services. I agree to pay for services rendered, including attorney's fee, collection charges and court cost necessary to affect payment of this account. I also understand that interest charges of 1 ½ % per month may be charged should my account become delinquent.

A photocopy of this authorization shall be considered as effective and valid as the original.

Lifetime Patient Signature: _____ Date: _____

(Your signature is required which will allow us to bill your insurance company.)

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