Gulfstream Urology Associates, PA

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_________	Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]

Residence address City State Zip	Home Phone:	Patient's Social Security #

Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #

Responsible Party Drivers License # State: Number	Occupation	How Long at current Employer?
Credit Card: Number: Type [ ] Mastercard [ ] Visa [ ] Discover	Expiration Date:	Name On Card
Name of employer Address	Business Phone	Occupation

Name of Spouse/Parent	Birth date	Social security #	Business phone

Reason for Visit:	Referred by: (include address and phone)

Person to contact in case of emergency:	Relationship to patient	Phone

Medicare Yes [ ] No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date

Medicare Secondary insurance name Address	Policy #	Group #

Workers' Compensation? Yes **[ ]** No **[ ]** Motor Vehicle? Yes **[ ]** No **[ ]** **If Yes-put W/C or MVA carrier below**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #

Primary insurance company Address	Is insurance through your employer?

Subscriber Name	Subscriber birth date	Policy #	Group #

Secondary insurance name Address	Policy #	Group #

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Practice Name for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_________________________________ _________________
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Practice Name for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_________________________________ _________________
Patient, Parent or Guardian Signature (if child is under 18 years old) Date