

Park Ave Urology, P.C.
Patient Information – Complete in Full – Please Print

NAME OF PATIENT		SEX	AGE	DATE OF BIRTH
ADDRESS		CITY & STATE		ZIP
HOME PHONE #		OFFICE PHONE #		SINGLE MARRIED
SOCIAL SECURITY		DRIVER'S LICENSE		
E-MAIL ADDRESS		ADDRESS		PHONE #
PATIENT'S EMPLOYER		EMPLOYER ADDRESS		PHONE #
OCCUPATION		CITY & STATE		ZIP
NAME OF SPOUSE		SOCIAL SECURITY		DATE OF BIRTH
SPOUSE EMPLOYER		EMPLOYER ADDRESS		PHONE #
OCCUPATION		CITY & STATE		ZIP
NAME OF NEAREST RELATIVE OR FRIEND	NAME OF NEAREST RELATIVE OR FRIEND	PHONE # OF RELATIVE OR FRIEND		
ADDRESS		CITY & STATE		ZIP
REFERRING PHYSICIAN		AREA CODE & PHONE #		
ADDRESS		CITY & STATE		ZIP
PLEASE LIST MEDICATIONS YOU ARE ALLERGIC TO:				

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO.		PHONE #	NAME OF PERSON INSURED	
NAME OF EMPLOYER HELD THROUGH		ADDRESS WHERE CLAIMS SHOULD BE SENT		
POLICY #	GROUP #	PAYOR I.D. #		PAYOR SUB I.D. #
NAME OF SECONDARY INSURANCE CO.		PHONE #	NAME OF PERSON INSURED	
NAME OF EMPLOYER HELD THROUGH		ADDRESS WHERE CLAIMS SHOULD BE SENT		
POLICY #	GROUP #	PAYOR I.D. #		PAYOR SUB I.D. #

In order to control our billing costs, we request payment for our office visits at the time the service is rendered. We would rather control our billing costs than be forced to raise our fees.

AUTHORIZATION & ASSIGNMENT OF BENEFITS
(Please Read & Sign)

I hereby authorize Dr. _____ to furnish information to my insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____