UROLOGY CENTER
PATIENT DEMOGRAPHIC & INSURANCE INFORMATION (2017)

LAST NAME: _____FIRST NAME_____MIDDLE NAME_____

AGE: _____ **Date of Birth**: _____Soc. Sec: _____-_____-_____ **Sex** ❑M ❑F

OTHER/ PREVIOUS NAME (S): _____

ADDRESS: _____ Apt# _____

CITY: _____STATE: _____ZIP: _____

HOME **PHONE**: _____ CELL: _____WORK PHONE: _____EXT: _____

MARITAL STATUS: (Please Circle) Single Married Divorced Widow(-er) Living Together Separated

PATIENT'S OCCUPATION: _____ full-time part-time
Employer: _____
Employer's Address: _____
If Student, School: _____ full-time part-time

Name of Spouse/Significant Other: _____
Occupation: _____ work phone: _____
Employer: _____

EMERGENCY CONTACT NAME: _____
Home phone: _____ Work Phone: _____
Relationship: _____

NAME OF PRIMARY CARE PHYSICIAN/FAMILY PHYSICIAN: _____

Name of Person Financially Responsible for Your Account: **Self Spouse Other**_____ _____

PRIMARY INSURANCE: Effective Date: _____ Termination Date: _____

INSURANCE NAME: _____ PHONE: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

POLICY HOLDER'S NAME: _____ **DOB:** _____

RELATIONSHIP: _____ SS#_____-_____-_____

EMPLOYER: _____ **SAME HOME ADDRESS AS PATIENT?** Yes No

POLICY OR ID # _____ GROUP #: _____

SECONDARY INSURANCE: Effective Date: _____ Termination Date: _____

INSURANCE NAME: _____ PHONE: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

POLICY HOLDER'S NAME: _____ **DOB:** _____

RELATIONSHIP: _____ SS#_____-_____-_____

EMPLOYER: _____ **SAME HOME ADDRESS AS PATIENT?** Yes No

POLICY OR ID # _____ GROUP #: _____

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NOTE: Signature needed, please read carefully and sign with date below:

CONSENT TO TREATMENT: I consent to any medical treatment deemed medically necessary by the physician. I understand that these treatments will be discussed with me and all questions answered before it is rendered.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my examination to my insurance company, another doctor or hospital, adjuster or attorney.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to Urology Center / Michael P. Verni, M.D., Ltd. For any surgical and/or medical benefits, if any, otherwise payable to me for services provided. A photocopy of this assignment of benefits shall be considered as effective and valid as the original. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. The Lab will bill ANY LAB TESTING done in the office separately.

AGREEMENT TO PROVIDE COMPLETE & CURRENT INFORMATION:
1. I agree to notify this office at the time of any future service if there has been any change in my address, phone number(s), employer, primary care physician, or insurance coverage.
2**. I have provided the name of ALL the insurance policies of which I am a member at this time. I will notify this office of any changes at the time of future service or appointments (or at the time of scheduling the appointment) if there are any changes in my membership status in any of my medical insurance policies. I acknowledge that to withhold this information is INSURANCE FRAUD. I acknowledge that if I give incorrect information, I will be held responsible for all penalties and refunds due, and that I will be responsible for the full cost of my care at my own personal expense.**

SIGNATURE: _____ DATE: _____