PATIENT INFORMATION

Patient's SSN _____

Male ☐ Female ☐ Email _____

Patient's Name _____
(Last) (First) (Middle)

Patient's Address _____
(Street or P.O. Box) (City) (State) (Zip Code)

Phone Numbers: Home _____ Work _____ Cell _____

Birth Date _____ Age _____ Referring and/or Family Physician _____

Race (Optional): _____ Ethnicity (Optional): ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Patient's Employer _____

Employer's Address _____

Spouse's Name _____ SSN _____ Employer _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

IF PATIENT IS A CHILD:

Mother _____ SSN _____ Employer _____ Phone # _____

Father _____ SSN _____ Employer _____ Phone # _____

Primary Insurance: _____ Group _____ Policy # _____

Policy Holder Name _____ SSN _____ *DOB _____

Secondary Insurance: _____ Group _____ Policy # _____

Policy Holder Name _____ SSN _____ *DOB _____

**We must have the date of birth of the Insurance Policy Holder to file your insurance claims.*
*** Please attach Insurance Card(s) and Driver's License so we can make a copy for your records.***

Please Note:

Office visits, office surgeries, non-surgical treatments, and some hospital procedures are paid at the time of service unless you have a contract insurance such as Medicare, BC/BS, Cigna, Blue Choice, etc. If you are using contract insurance, you will be required to pay your co-payment and/or deductible at the time of service.

I understand that I am responsible for all charges until paid. I understand that I am responsible for obtaining prior authorization, all deductibles, co-payments, and cost shares, including deductible and co-payments.

Authorization: I authorize Drs. Ploch, Brisson and Nickles of Palmetto Adult and Children's Urology, PA to release medical information to insurance carriers and medical professionals concerning my illness or treatments. I authorize payment of medical benefits to the physicians of Palmetto Adult and Children's Urology, PA for services rendered.

Patient's Signature _____ Date _____
(Parent or Guardian if patient is a minor)

Revised 8/2018