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. Goulding, Ploch and Brisson 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 3/2012