ATLANTIC COAST UROLOGY, PA
ADULT AND PEDIATRIC
UROLOGY AND GENITOURINARY SURGERY

PATIENT INFORMATION

Name_____ SS#_____
FIRST MI LAST

Mailing Address_____ City_____

State_____ Zip_____ Date of Birth_____ Male_____ Female_____

Home Phone(___)_____ **Cell Phone (___)**_____ Work Phone(___)_____

Please check appropriate space: Minor_____ Single_____ Married_____ Widowed_____ Divorced_____

Patient's pf Parent's Employer_____

Business Address_____

Spouse or Parent's Name_____

Are you, parent or spouse currently an active member of the military? Yes_____ No_____ If yes please indicate name, relationship, branch of service_____

Whom may we "thank" for sending you?_____

Allergies?_____
DRUGS-FOODS

Person to contact in case of emergency_____

Relationship_____ Phone(___)_____

RESPONSIBLE PARTY

Person responsible for this account_____ Relationship_____
Employer_____ Phone(___)_____
Birthdate_____ SS#_____ Work Phone(___)_____

INSURANCE INFORMATION

Please give your **insurance cards** to our staff so we can make a copy of them.

PRIMARY INSURANCE

Company_____

Insurance Company Address_____

Name of Insured_____ Relationship to Insured_____

SS# of Insured_____ ID#_____ Group_____

How much is your deductible?_____ Insured date of birth?_____

Primary Physician_____ Is this a managed care program(HMO)? Yes_____ No_____

Primary Physicians Address_____

Primary Physicians Phone(___)_____ Group Name_____

Pharmacy Name_____Phone(___)_____

Pharmacy Address_____

SECONDARY INSURANCE

Company_____

Insurance Company Address_____

Name of Insured_____Relationship to Insured_____

SS# of Insured_____ID#_____Group_____

Name of Employer_____Phone(___)_____

How much is your deductible?_____ Insured date of birth?_____

Primary Physician_____Is this a managed care program(HMO)? Yes___No___

Primary Physicians Address_____

Primary Physicans Phone(___)_____Group Name_____

TO OUR PATIENTS:

Our office will attempt you with the completion of your insurance claim. However, each patient, not the insurance company, is responsible for payment to this office. Our office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

Due to the increasing completity of insurance policies with regard to PRE-CERTIFICATION, ASSISTANT SURGEON, SECOND OPINIONS, tec., for hospital stays and operations, YOU ARE RESPONSIBLE for notifying your insurance company before being admitted to the hospital. This will help avoid unnecessary denials or lowering of payment for failing to follow the OBLIGATIONS of YOUR POLICY.
We cannot be responsible for any loss of benefits. It is YOUR RESPONSIBILITY TO KNOW YOUR POLICY.
The doctors of Atlantic Coast Urology have a financiall interest in the following facilities; Shore OutPatient Surgicenter, Shore Point Radiation Oncology, Shrewsbury Surgicenter, **Center for Ambulatory Minimally Invasive Surgery**

Authorization & Release

I, the undersigned, hereby authorize payment of medical benefits to ATLANTIC COAST UROLOGY, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract.

I authorize release of information concerning my (or my child's) health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X_____
Signature of patient(or parent if minor) Date

MEDICARE LIFETIME SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on *my behalf to ATLANTIC COAST UROLOGY, PA for any services furnished me by the physician. I authorize any* holder of medical infofmation about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

X_____
Signature PHOTO COPY AS VALID AS ORIGINAL Date