UROLOGY CENTER OF WESTCHESTER

Appt. Date/Time: _____ Dx: _____
MM Acct#: _____ MR# _____ Appt in MBA: _____
Records Requested: _____ Reports Received: _____
Pt will bring in reports: _____ NP Packet Mailed: _____

Choudhury **Eshghi** **Matthews** **Phillips** **Fullerton** **Allman**

First Name: _____ Last Name: _____
Date of Birth: _____ **Social Sec #:** _____
Sex: M _____ F _____ Home Phone #: _____
Address: _____ Cell Phone #: _____
City: _____ Business #: _____
State: _____ Zip Code: _____ **Marital Status:** S M D W
Emergency Contact: _____
Employed: Y _____ N _____ Relationship: _____
Employer/School: _____ Phone #: _____

Referring Physician: _____ Other Physicians: _____
Address: _____ Address: _____

Phone: _____ Phone: _____
Fax: _____ Fax: _____

PRIMARY INSURANCE

Insurance Company: _____ Insured: _____
Insurance ID#: _____ Group ID#: _____
Street Address/PO Box: _____
City: _____ State: _____

SECONDARY INSURANCE

Insurance Company: _____ Insured: _____
Insurance ID#: _____ Group ID#: _____
Street Address/PO Box: _____
City: _____ State: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier's payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with out office bookkeeper.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policyholder: _____ SSN: _____

Regulations pertaining to Medicare assignment of Medicare apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its indemnities or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

SIGNATURE: _____ **DATE:** _____