

PLEASE FILL IN ALL THE BLANKS — IF NONE, WRITE "NONE". PLEASE USE BLUE OR BLACK INK. NO PENCIL. BE SURE TO ALSO SIGN AND DATE.

PATIENT ACCOUNT NUMBER _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY NO. _____

STREET ADDRESS _____ APT/PO BOX/LOT NO. _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____ CELL PHONE _____

HAVE YOU EVER BEEN SEEN BY THIS OFFICE UNDER ANY OTHER NAME? YES NO _____ PREVIOUS NAME _____

ARE YOU ENROLLED IN HOSPICE? YES NO IF YES, WHAT COUNTY _____

ARE YOU A RESIDENT OF A SKILLED NURSING FACILITY? YES NO NAME _____

EMERGENCY CONTACT: _____ NAME _____ PHONE _____ RELATIONSHIP TO PATIENT _____

REFERRING DOCTOR _____ FAMILY DOCTOR _____

PHARMACY NAME _____ PHONE _____ LOCATION _____

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED

PATIENT EMPLOYED FULL TIME PART TIME NOT EMPLOYED RETIRED SELF EMPLOYED DISABLED

PATIENT'S EMPLOYER _____ EMPLOYER'S STREET ADDRESS _____

EMPLOYER'S CITY/STATE/ZIP _____ PHONE _____

WORKERS COMPENSATION: MUST HAVE LETTER OF AUTHORIZATION FROM EMPLOYER.

IS THIS WORK RELATED? YES NO DATE OF INJURY _____

COMPENSATION CARRIER NAME & ADDRESS _____

IS THIS A RESULT OF AN AUTOMOBILE ACCIDENT? YES NO IF YES, PLEASE HAVE AUTO INSURANCE INFORMATION AVAILABLE.

YOU WILL BE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE OR BALANCE AT THE END OF EACH VISIT.

SPOUSE'S NAME _____ BIRTH DATE _____ SOCIAL SECURITY NO. _____

SPOUSE EMPLOYED? FULL TIME PART TIME NOT EMPLOYED RETIRED SELF EMPLOYED DISABLED

SPOUSE'S EMPLOYER _____ EMPLOYER STREET ADDRESS _____

EMPLOYER'S CITY/STATE/ZIP _____ PHONE _____

I authorize my verbal or written information be released to: _____

(SPOUSE, CHILD, FRIEND, GUARDIAN, ETC.)

I REQUEST THAT NO INFORMATION BE RELEASED _____ (Initials)

NOTICE OF PRIVACY PRACTICES – I have been notified of and provided access to a copy of the West Shore Urology, P.L.C. Notice of Privacy Practices.

PAYMENT AGREEMENT – I understand West Shore Urology will bill for most services provided to me. If I do not have insurance, I agree to pay West Shore Urology for all charges for services provided to me as requested. If I have health insurance which covers services I received, I understand I am responsible, if for some reason, West Shore Urology is not paid by an insurer for the services I received, unless health insurer has an agreement with West Shore Urology which prohibits billing me for services. I agree to pay West Shore Urology the amount of any charges not covered by or disputed by the insurance, worker's compensation carrier or employer. I understand for any unpaid balance, West Shore Urology will use the services of a third party collection agency to collect any outstanding balance.

MEDICAL RELEASE – I hereby authorize West Shore Urology, P.L.C. to disclose any medical records or other information pertaining to my treatment, hospitalization or outpatient care to the my insurance company, employer or acting intermediary. A photocopy of this authorization shall be valid as the original.

INSURANCE AUTHORIZATION – I also authorize payment of medical benefits to be sent directly to West Shore Urology, P.L.C. (Tax ID# 38-1969372) for any services rendered. I have read this form (or have had it read to me) and I understand it. I agree that by signing this form I am bound by what it says whether I am the patient or someone acting on the patient's behalf. For the protection and proper treatment of patients, medical staff and health care personnel, I understand that I may need to be tested for human immunodeficiency virus (HIV) and Hepatitis if a health professional or office associate sustains a percutaneous (needle stick), mucous membrane or open wound exposure to my blood or other body fluids.

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____

PATIENT NAME: _____

DATE OF BIRTH: _____

How did you hear about our office?

- FAMILY PHYSICIAN FAMILY / FRIEND WEB SITE
 PHONE BOOK, If so, which one? VERIZON YELLOW BOOK SBC

IF A MINOR, PLEASE COMPLETE:

FATHER'S NAME _____ **BIRTH DATE** _____

SOCIAL SECURITY NO. _____ HOME PHONE _____ CELL PHONE _____

HOME ADDRESS _____ CITY/STATE/ZIP _____

FATHER'S EMPLOYER _____ EMPLOYER'S STREET ADDRESS _____

EMPLOYER'S CITY/STATE/ZIP _____ PHONE _____

MOTHER'S NAME _____ **BIRTH DATE** _____

SOCIAL SECURITY NO. _____ HOME PHONE _____ CELL PHONE _____

HOME ADDRESS _____ CITY/STATE/ZIP _____

MOTHER'S EMPLOYER _____ EMPLOYER STREET ADDRESS _____

EMPLOYER'S CITY/STATE/ZIP _____ PHONE _____