Urology Specialists of Atlanta, L.L.C.

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PATIENT INFORMATION (Please Print) ☐ Male ☐ Female Date ____________________

Patient ____ Social Security NO. ____________________

Marital Status ______________ Birth Date ______________ Email ______________________________

Address ____

City ____________________ State ______________ Zip________ Name of Spouse____________________

Home Phone (_____) ______________Work Phone (_____) ______________ Cell Phone (_____) ______________

IN CASE OF EMERGENCY OR INABILITY TO REACH PATIENT PLEASE CALL:

Name________________________________ Phone (_______) ________________Relationship ______________

Who may we thank for referring you? ____

Primary Care Physican ____

Employer's Name ______________________________Phone (________________)________________

Address ______________________________ City__________ State ______________Zip______________

PRIMARY INSURANCE PLAN NAME: ____

Insured's Group Policy Number __________________________ Insured's ID Number ____________________

Insured if other than patient __________________________ Birth Date____________________________

Insured Person's Employer ____________________________ Phone (_______) ____________________

Please indicate if appropriate ☐ HMO ☐ PPO

IS THERE ANOTHER HEALTH PLAN - INS. CO. NAME:____________________________________

Insured's Group Policy ______________________________ Insured's ID Number ____________________

Insurance Co.Address ____________________________City ____________ State ________ Zip ____________

Insured's Name ________________________________Birth Date ________ Employer ________________

Employer's Address ______________________________City ____________ State ________ Zip ____________

Insured's Relationship to Patient ☐ Spouse ☐ Patient Other: ______________________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information acquired in the course of my examination or treatment to insurance carriers.

SIGNED ____ DATE______________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits direct to Urology Specialists of Atlanta, L.L.C. for medical/surgical services rendered to me or my dependents.

SIGNED ____ DATE______________________________

Please complete all information and attach a copy of your insurance card to this form so that the receptionist may copy it for the file.