NEW PATIENT INFORMATION RECORD

CENTRAL BUCKS UROLOGY, P.C.

DATE

Please **PRINT** All Information

PATIENT INFORMATION

PATIENT'S NAME (Last, First, M.I.)				
STREET ADDRESS		CITY	STATE	ZIP
S.S. #		HOME PHONE	WORK PHONE	
SEX: ☐ MALE ☐ FEMALE	MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	AGE	DATE OF BIRTH	HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE? ☐ YES ☐ NO IF YES, WHEN: _____
OCCUPATION			EMPLOYER	
WORK ADDRESS				
SPOUSE'S NAME		SPOUSE'S DATE OF BIRTH	SPOUSE'S S.S. #	
PHARMACY	PHARMACY #			
PREFERRED LANGUAGE		RACE	ETHNICITY	

PERSON RESPONSIBLE FOR PAYMENT (Spouse, Parent, Guardian, Self, etc.)

NAME	DATE OF BIRTH	RELATIONSHIP
ADDRESS		
OCCUPATION	EMPLOYER	PHONE
ADDRESS		WORK PHONE

POLICY HOLDER INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER
GROUP #	CERTIFICATE / POLICY / ID #
MEDICARE #	DATE OF BIRTH

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER
GROUP #	CERTIFICATE / POLICY / ID #
MEDICARE #	DATE OF BIRTH

_____

Family and/or Referring Physician

_____

Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

"I authorize **STEVEN C. FLASHNER, M.D. / ALBERT RUENES, JR., M.D. / KEVIN B. FITZGERALD, M.D. / FRANK H. ROLAND, JR., M.D.** to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance."

Signed _____ Date _____