

NEW PATIENT INFORMATION SHEET

DATE _____

PLEASE PRINT CLEARLY

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

MARITAL STATUS _____ SOCIAL SECURITY NO. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ REFERRING DOCTOR _____

EMPLOYER _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE (OR PARENT OF MINOR) _____

SPOUSE'S EMPLOYER _____ PHONE _____

CONTACT PERSON IN CASE OF EMERGENCY _____ PHONE _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME _____ PHONE _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME _____ PHONE _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

WORKMAN'S COMP INFORMATION

INSURANCE CO NAME _____ PHONE _____

EMPLOYER AT TIME OF INJURY _____ PHONE _____

DATE OF INJURY _____ REPORTED TO _____

NOTICE OF PRIVACY PRACTICES AVAILABILITY

Georgia Regional Urology, P.C.'s Notice of Privacy Practices is available for your review posted in our waiting room and both exam rooms. If you wish to receive a copy of this notice it is available. Please just make our receptionist aware that you wish to receive a copy.

I do not wish to receive a copy.

I do wish to receive a copy.

Also available for you is a copy of OWNERSHIP OF PRACTICE AND EXPERTISE OF PHYSICIAN, PATIENTS RIGHTS AND RESPONSIBILITIES, DNR POLICY, INFORMATION REGARDING THE GRIEVANCE PROCEDURE AND INFORMATION REGARDING OUR BILLING PRACTICE.

Signature

Date

Payment is expected at the time service is rendered if there is no insurance to file. We will file insurance for patients who have coverage.

I authorize Georgia Regional Urology, P.C./David L. Perlow, M.D. to release any and all information regarding diagnosis, treatment, and prognosis with respect to any physical condition and/or treatment of me to my insurance company or its legal representative. Any such disclosure shall be limited to information that is reasonable and necessary for the discharge of the legal or contractual obligations of the insurance company. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand that the information obtained by use of this authorization will be used by my insurance company to determine eligibility for benefits under an existing policy. Any information obtained may only be released by my insurance company to any other person or organization as governed by HIPAA or unless I so authorize.

I also authorize payment of all medical benefits to be made payable to David L. Perlow, M.D./Georgia Regional Urology, P.C.

I give my permission to be examined and treated by David L. Perlow, M.D.

Signature of Patient or Parent of Minor

Date