COMMONWEALTH UROLOGY, P.S.C.

Date: _____

Patient Name: _____ Age: _____ Birth Date: _____ Sex: _____

Guarantor Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency # _____ Pager _____ Other _____ Email _____ Fax _____

Marital Status: _____ Occupation: _____

Referred By _____ Family Physician _____

Pharmacy Name _____ Phone # _____

Employer: _____ Address: _____

Phone #: _____

Spouse's Name: _____ Occupation _____

Employer: _____ Address _____

Phone #: _____ SSN# _____

Primary Insurance: _____ Address _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Relationship To Patient: _____ Employer _____

Secondary Insurance: _____ Address _____

Subscriber's Name: _____ SSN#: _____ DOB: _____

Name Of Nearest Relative Not Living With You: _____ Phone #: _____

Is this Work Related? Yes☐ No☐ If so, where does bill go? _____ Claim#: _____

ASSIGNMENT AND RELEASE

1. _____

2. _____

I, the undersigned, certify that I (or my dependent) have coverage with (print name of insurance company above) and assign directly to Commonwealth Urology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

APPLICABLE TO MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release that information to the Social Security Administration, the Medicare Program or their intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

_____ _____ _____

Responsible Party Signature | Relationship to Patient | Date