Urological Consultants
OF FLORIDA

# NEW PATIENT REGISTRATION FORM

**Date:**_____

**Patient Name:**_____**Date of Birth:**_____**Age:**_____

**Local Address:**_____**Apt #:**_____

**City:**_____**State:**_____**Zip Code:**_____

**Home Telephone: (  )**_____**Daytime Telephone: (  )**_____

**If a patient is a MINOR, patient's or guardian's**

**Name:**_____**Relationship:**_____

**Language(s) Spoken:**_____

**Sex: (  )Male (  ) Female Marital Status: (  ) Single (  )Divorced (  ) Married (  ) Other**

**SS#:**_____/_____/_____

**Employer:**_____**Telephone: (  )**_____

**Address:**_____**Occupation:**_____

**Primary Care Physician:**_____**Referred By:**_____

**Next of Kin:**_____**Relationship:**_____

**Home Telephone: (  )**_____**Work Telephone: (  )**_____

**Insurance Company:**_____

**Your Pharmacy of Choice:**_____**Telephone: (  )**_____

**Please Complete Second Page, Thank You**



North Miami Office P: (305) 672-4222 F: (305) 672-4561 12411 Biscayne Boulevard, North Miami FL 33181
www.ucofl.com

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## MEDICAL AUTHORIZATION AND LIFETIME PATIENT SIGNATURE

**I request that payment of authorized insurance benefits either to me or on my behalf be made payable to UROLOGICAL CONSULTANTS OF FLORIDA, P.A. for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to UROLOGICAL CONSULTANTS OF FLORIDA, P.A., that will be billed and I agree to pay for said services. I agree to pay for services rendered, including attorney's fee, collection charges and court cost necessary to affect payment of this account. I also understand that interest charges of 1 ½ % per month may be charged should my account become delinquent.**

**A photocopy of this authorization shall be considered as effective and valid as the original.**

**Lifetime Patient Signature:_____Date:_____**

**(Your signature is required which will allow us to bill your insurance company.)**



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