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

Miami Beach Office P: (305) 672-4222 F: (305) 672-4561 4302 Alton Road, Suite 920, Miami Beach FL 33140
North Miami Office P: (305) 944-0025 F: (305) 944-3624 1400 Miami Gardens Drive, Suite 209, North Miami FL 33179
www.miamiurologyconsultants.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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