

PATIENT REGISTRATION



Email Address _____

PRIMARY CARE PHYSICIAN _____

PHARMACY _____ PHARMACY PHONE #: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ DOB ____/____/____
Social Security # _____ Marital Status _____ Circle One Single Divorced
Driver's License # _____ Married Widowed Separated
Address _____ City _____ State _____ Zip _____
Home Phone # (____) _____ Work Phone # (____) _____ Cell Phone # (____) _____ Code _____

PATIENT CONTACT INFORMATION

Central Florida Urogynecology and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account. Please circle if EMERGENCY CONTACT ONLY.

Name _____ Relationship _____ Phone _____

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I understand authorizing the release of this information is voluntary and does not affect my access to treatment. I can refuse to make authorization. I understand this authorization will remain in effect until I revoke it by completing a new form. I understand if this information is shared with these individuals above, that they may disclose my protected health information to other individuals. I have indicated my agreement with this authorization by signing below.

REFERRAL INFORMATION

Referred by Doctor _____ Relative _____ Friend _____ Other _____

INSURANCE INFORMATION

Primary Insurance _____
Contract or Policy # _____ If Medicare, Do you have part B Yes ____ or No ____
Group # _____ Does your Insurance require a referral? Yes ____ or No ____ How much is your Co-Pay? _____

Other Insurance: Name _____ Contract or Policy # _____ Group # _____

Insured: Name _____ Address: _____ City _____ State _____ Zip code _____

Relationship: Self ____ Child ____
Phone # (____) _____ to Insured : Spouse ____ Other ____ DOB ____/____/____

Insured: Social Security # _____

I accept full responsibility for all charges for services rendered by Central Florida Urogynecology. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of medical information necessary for completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Central Florida Urogynecology. I understand any balance left after insurance has settled claim is my responsibility. I agree to promptly pay any outstanding balance. I have read all of the information on this form and agree to these policies.

Patient's or Authorized Representative's Signature _____ Date _____