

SUMMIT UROLOGY

Please do not leave any line blank. If it does not apply to you, please write N/A. All information is required for billing purposes. Thank you for your cooperation.

Last Name: _____			First Name: _____			MI: _____		
Street Address: _____								
City: _____			State: _____			Zip Code _____		
Home Phone: () _____ - _____			Work Phone: () _____ - _____			Sex: M F		
***I authorize messages to be left on my answering machine/voicemail from physician, nurses or staff members of Summit Urology Specialists. The numbers that I authorize messages to be left at are: (please initial next to) _____ Home _____ Work _____ Other _____ - _____ - _____								
Age: _____		Date of Birth: ____/____/____			Social Security #: _____ - _____ - _____			
Employer: _____						Student: _____ No _____ Yes, Full time or Part Time (Circle one)		
Referred By: _____ (First & Last Name)				Family Doctor: _____ (First & Last Name)				
Pharmacy: _____						Location: _____		
Preferred Pharmacy for Prescriptions								

Primary Insurance _____			Policy # _____			Grp# _____		
Subscriber Name _____						Subscriber Social Security#: _____		
Subscriber Address: _____								
Subscriber Date of Birth: ____/____/____			Subscriber Employer: _____					
Please circle Subscriber's relationship to Patient: Self Spouse Parent Guardian								

Secondary Insurance _____			Policy _____			Grp# _____		
Subscriber Name _____						Subscriber Social Security#: _____		
Subscriber Address: _____								
Subscriber Date of Birth: ____/____/____			Subscriber Employer: _____					
Please circle Subscriber's relationship to Patient: Self Spouse Parent Guardian								

I authorize payment of medical benefits to Summit Urology for services rendered and authorize release of any medical information necessary to process this claim. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.								
Signature _____						Date _____		
***I authorize Summit Urology Specialists, to discuss information regarding my medical treatment with:								
_____						ph# _____ - _____ - _____		
Signature _____						Date _____		