Florida Urology Partners, LLP

PATIENT INFORMATION

Please print

Last Name _____ First name _____ MI _____

Date of Birth _____ Home Phone _____ Work Phone _____

Address _____ Apt or Lot # _____

City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Primary Care doctor _____ Your SS# _____

Male _____ Female _____ Marital Status: Single Married Other (please circle)

Name of Spouse _____ Spouse Date of Birth _____

Spouse's Employer _____ Employer Phone _____

Other Emergency Contact _____ Relationship _____

Do you attend school? _____ Full Time _____ Part Time _____

Name of School _____

Alternate Home Address _____ Phone _____

City _____ State _____ Zip Code _____

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Primary Insurance _____ Effective Date _____ PPO/HMO _____

Mailing Address _____

City _____ State _____ Zip Code _____

ID# _____ Group # _____

Insured's Name _____ Relationship to you _____

Secondary Insurance _____ Effective Date _____ PPO/HMO _____

Mailing Address _____

City _____ State _____ Zip Code _____

ID# _____ Group # _____

Insured's Name _____ Relationship to you _____

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I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I Authorize release of any information necessary for medical care or in processing of medical claims. I request that payment of authorized benefits be made on behalf. I assign the benefits payable to Frank Mastandrea, M.D., and authorize such physician to submit a claim to my insurance company for payment. I understand that I am financially responsible for any balance not covered by my insurance. A photocopy of these assignments shall be valid as the original.

Patient's Signature _____ Date _____