# WELCOME TO GREENWICH UROLOGICAL ASSOCIATES

## PATIENT INFORMATION

| PATIENT'S LAST NAME | FIRST NAME | MIDDLE | AGE | DATE OF BIRTH | MARITAL STATUS |
|---|---|---|---|---|---|
| | | | | | |

| HOME ADDRESS | CITY | STATE | ZIP | HOME PHONE |
|---|---|---|---|---|
| | | | | |

| PARENT'S NAME (IF PATIENT IS UNDER 18 YEARS OLD) | SOCIAL SECURITY NUMBER FOR PATIENT (OR PARENT) | SOCIAL SECURITY NUMBER FOR CARDHOLDER (IF DIFFERENT) |
|---|---|---|
| | | |
| **PATIENT'S (OR PARENT'S) EMPLOYER** | **BUSINESS PHONE** | **CELL PHONE** |
| | | |
| **EMPLOYER'S ADDRESS** | **OCCUPATION** | |
| | | |
| **NAME OF SPOUSE** | **SPOUSE'S WORK NUMBER** | |
| | | |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| A | **For Medicare Patients:** | | |
| | 1. Do you have Medicare Part B? (Payment of Doctor's Charges) | ☐ Yes ☐ NO | ID # |
| | 2. If your Medicare is primary, what insurance is secondary? | | ☐ None |
| | 3. If your Medicare is secondary, what insurance is primary? | | |
| B | **For Non-Medicare Patients:** | | |
| | 1. Primary Insurance Carrier: | | Policy Holder's ID #: |
| | 2. Secondary Insurance Carrier: | | Policy Holder's ID #: |
| | 3. Policy Holder's Name: | | Policy Holder's Birth Date: |
| C | Do you have Medicaid / Welfare / Title 19? ☐ Yes ☐ NO | | If yes, ID #: |
| D | Is your condition work-related? ☐ Yes ☐ NO | | If yes, Worker's Comp Carrier: |
| E | Is your condition due to an auto accident? ☐ Yes ☐ NO | | If yes, No-Fault Carrier: |

## MEDICAL INFORMATION

| | | | |
|---|---|---|---|
| F | Who referred you to this office? | Dr. | Other: |
| G | Do we have your approval to leave personal lab/test results on your answering machine? | | ☐ Yes ☐ NO |
| H | May we speak to a family member or friend regarding your care? | | ☐ Yes ☐ NO |
| | If YES, what is the name of that person? | | |
| I | Who is your Primary Care Doctor? | | |
| J | What is the name, location, and phone number of your pharmacy? | | |
| K | What is the name and phone number of the person to contact in case of an emergency? | | |

## *Payment Policy – Medical Authorization – Assignment of Benefits*

- Greenwich Urological Associates participates with Medicare. That means Medicare will pay Greenwich Urological Associates 80% of allowed charges. You are responsible for the 20% co-insurance, your annual deductible and any non-covered charges. You will be informed of non-covered charges in advance.
- If we participate with your insurance, payment of your co-pay is expected at time of service.
- **If your insurance requires a referral, it is your responsibility to make sure you have a valid referral prior to your visit. If you do not have a valid referral, you will be responsible for all charges not paid by your insurance.**
- If Greenwich Urological Associates does not participate with your insurance, payment is required at time of service. We will provide you with an itemized form to submit to your insurance carrier.
- I authorize Greenwich Urological Associates to release any medical information necessary in order for my insurance company to process my claims. I authorize payment of medical benefits to be made directly to Greenwich Urological Associates, P.C. for any fees not paid at time of service.
- I have read, understand, and agree to all of the above.

Signature of Patient or Guardian _____ Date _____

REV 02-12-04