

# PATIENT INFORMATION

## REGISTRATION (Please Print)

Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First Initial

Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address If Different \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed By \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ Relation \_\_\_\_\_ Hm/Wk Phone (\_\_\_\_) \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Do you have an Advance Directive?  Yes  No

## Person Responsible for Account

Last First Initial

If patient is a minor, do you have custody?  Yes  No

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance** \_\_\_\_\_ Who carries the insurance?  You  Spouse

Insured's Date of Birth \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber/Policy # \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Who carries the insurance?  You  Spouse

Insured's Date of Birth \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber/Policy # \_\_\_\_\_

## **ASSIGNMENT AND RELEASE**

I authorize my insurance to be paid directly to the doctor. I am financially responsible for any balance due.

I authorize the doctor or insurance company to release any information required for this claim.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Longview Urology, PLLC dba Salmon Creek Urology for any services furnished me by that entity. 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 payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay this claim. If "other health insurance" is indicated in item 9 of the HCFA - 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_