

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)	<input type="checkbox"/> Yes <input type="checkbox"/> NO	ID #		
	2. If your Medicare is primary, what insurance is secondary?				<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	If yes, ID #:		
D	Is your condition work-related?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	If yes, Worker's Comp Carrier:		
E	Is your condition due to an auto accident?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> NO	
H	May we speak to a family member or friend regarding your care?	<input type="checkbox"/> Yes <input type="checkbox"/> 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