UROLOGY CONSULTANTS OF THE NORTH SHORE, INC.

PATIENT INFORMATION

PLEASE PRINT Date _____

Patient Name: Last _____ First _____ Middle Int. _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Sex: ☐Male ☐Female **Marital Status:** ☐Single ☐Married ☐Widowed ☐Divorced

Date of Birth _____ **Age** _____ **Social Security No.** _____

Primary Care Physician _____ **Referring Physician** _____

Employer's Name & Address _____

_____

Employer Phone ( ) _____

Emergency Contact _____ **Relationship** _____

Emergency Contact Phone ( ) _____

Pharmacy Name & Address _____

Patient, please read carefully and sign below:

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process an insurance claim including my authorization for payment of my medical benefits to be sent directly to UROLOGY CONSULTANTS OF THE NORTH SHORE, INC. I accept total responsibility for my payments for services rendered to me by UROLOGY CONSULTANTS OF THE NORTH SHORE, INC.

PATIENTS SIGNATURE _____ **Date** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I have received a copy of UROLOGY CONSULTANTS OF THE NORTH SHORE'S Notice of Privacy Practices.

PATIENTS SIGNATURE _____ **Date** _____