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 ☐Seperated ☐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 _____

Longview Urology, PLLC 625 9th Avenue, Suite 120 Longview, WA 98632 Phone (360) 425-3720 Fax (360) 425-0090

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