

PATIENT INFORMATION SHEET

DATE _____

PLEASE PRINT CLEARLY

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

MARITAL STATUS _____ SOCIAL SECURITY NO. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ CARRIER _____

EMAIL : _____

REFERRING DOCTOR _____

EMPLOYER _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE (OR PARENT OF MINOR) _____ DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____

SPOUSE'S EMPLOYER _____ PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST:

IF YOUR VISIT IS A WORKMAN'S COMP CLAIM PLEASE GIVE THE FOLLOWING INFORMATION

INSURANCE CARRIER NAME _____ PHONE _____

EMPLOYER AT TIME OF INJURY _____ PHONE _____

DATE OF INJURY _____ REPORTED TO _____

CLAIM NUMBER _____ CASE MANAGER _____

Payment is expected at the time service is rendered if there is no insurance to file. We will file insurance for patients who have coverage. Patient will be responsible for any balance on account that insurance does not cover.

I authorize Georgia Regional Urology, P.C./David L. Perlow, M.D. to release any and all information regarding diagnosis, treatment, and prognosis with respect to any physical condition and/or treatment of me to my insurance company or its legal representative. Any such disclosure shall be limited to information that is reasonable and necessary for the discharge of the legal or contractual obligations of the insurance company. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand that the information obtained by use of this authorization will be used by my insurance company to determine eligibility for benefits under an existing policy. Any information obtained may only be released by my insurance company to any other person or organization as governed by HIPAA or unless I so authorize.

I also authorize payment of all medical benefits to be made payable to David L. Perlow, M.D./Georgia Regional Urology, P.C.

I give my permission to be examined and treated by David L. Perlow, M.D.

X _____

Signature of Patient or Parent of Minor (**REQUIRED SIGNATURE**)

_____ Date

IF YOU WISH FOR OUR OFFICE TO DISCLOSE HEALTH INFORMATION TO A FAMILY MEMBER PLEASE INDICATE BELOW:

PERMISSION TO DISCLOSE INFORMATION TO THE FOLLOWING:

NAME _____

ADDRESS _____ PHONE _____

SPECIFIC INFORMATION TO BE DISCLOSED:

ALL RECORDS

OTHER EXPLAIN:

SIGNATURE OF PATIENT:

I have received a copy of Georgia Regional Urology, P.C.'s/Perlow Facility, LLC's Notice of Privacy Practices And Ownership of Practice and Expertise of Physician, Patients Rights and Responsibilities, DNR Policy, Information Regarding the Grievance Procedure and Information Regarding Our Billing Practice.

X _____

Signature of Patient or Guardian (**REQUIRED SIGNATURE**)

_____ Date