

The Urology Group

Walter M. O'BRIEN, MD Kevin P. O'CONNOR, MD
Nicholas G. LAILAS, MD Gregory S. SCHENK, MD
Darlene GAYNOR-KRUPNICK, DO
Madhu SINGH, PA Julie R. SPENCER, NP

PLEASE PRINT CLEARLY

NAME: (First) _____ (MI) _____ (Last) _____

ADDRESS: _____

CITY: _____

MARITAL STATUS: S M D W

SEX: M/F

STATE: _____ ZIP: _____

STUDENT: Y/N

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

SSN: _____

DATE OF BIRTH: _____

AGE: _____

EMERGENCY CONTACT: _____

PHONE: _____

RELATIONSHIP: _____

REFERRING DOCTOR: _____

PHONE: _____

PRIMARY CARE DOCTOR: _____

PHONE: _____

EMPLOYMENT INFORMATION:

MY EMPLOYER: _____ JOB TITLE: _____

ADDRESS: _____

IF OTHER THAN PATIENT, RESPONSIBLE PARTY INFORMATION:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ SSN: _____

NAME: _____ DOB: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID # _____ GROUP # _____

IF INSURANCE IS IN SOMEONE ELSE'S NAME, PLEASE COMPLETE: SELF

NAME OF INSURED _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ SSN _____ DATE OF BIRTH _____

INSURED'S EMPLOYER NAME/ADDRESS _____

METHODS TO CONTACT YOU:

I wish to be contacted in the following manner (check all that apply):

Home Telephone # _____ Written Communication

OK to leave message on home answering machine with detailed info (This includes test results, pre-op info, follow-up info, etc.) OK to mail to my home address OK to fax to this # _____

Leave message with call-back number only

DO NOT CALL MY HOME

Work Telephone # _____ Cell phone # _____

OK to leave message on work answering machine with detailed info OK to leave detailed message

Leave message with call-back number only Leave message with call-back number only

DO NOT CALL MY WORK

DO NOT CALL MY CELL PHONE

Other: _____

PLEASE BE ADVISED: WE CANNOT GIVE INFORMATION TO ANYONE WITHOUT YOUR WRITTEN CONSENT. IF YOU WANT SOMEONE ELSE (FOR EXAMPLE: YOUR SPOUSE) TO RECEIVE YOUR PERSONAL HEALTH INFORMATION, YOU MUST ASK THE RECEPTIONIST FOR AN AUTHORIZATION FORM. I UNDERSTAND THAT I MAY CHANGE MY METHODS OF CONTACT AT ANY TIME BY WRITTEN CONSENT.

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or my third party payer, health maintenance organization, insurer or other health benefit plan. This consent and authorization applies to LMG, PC/The Urology group.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG, PC/The Urology Group and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointment of which I did not notify the medical office within a reasonable amount of time.

I authorize LMG, PC/The Urology Group to test my blood for hepatitis and/or AIDS virus, if in their opinion, an employee has suffered exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. I also authorize the healthcare staff to perform the necessary health care services that I (my child) may need.

Signature

Date