MIAMI UROLOGY®
& SEXUAL WELLNESS INSTITUTE

Patient Information

Date: _____

Patient Name (Last, First, Middle Initial): _____

Local Address: _____

City: _____ **State:** _____ **Zip:** _____

☐ **Male** ☐ **Female** **Social Security #:** _____

Birth Date: _____ / _____ / _____ **Age:** _____

Local Phone: (_____ **)** _____ **Cellular Phone: (** _____ **)** _____

Email Address: _____

Home Away Address: _____

City: _____ State: _____ Zip: _____

Away Phone: (_____) _____

Patient's Employer: _____ **Work Phone: (** _____ **)** _____

Marital Status: _____ **Spouse's Name:** _____

Spouse's Employer: _____ Work Phone: (_____) _____

Spouse's Social Security #: _____ Spouse's Birth Date: _____/_____/_____

Nearest relative not living with you: _____ Phone: (_____) _____

Whom may we contact in case of emergency?: _____

Who is your primary physician?: _____ Phone: (_____) _____

Your preferred pharmacy: _____ Phone: (_____) _____

New Policy for Notification of Test Results

Due to federal guidelines, the practice is implementing a policy for notifying our patients about their test results.

Call Home # _____ Work # _____ Phone # _____

Please check the following which apply:

☐ I approve you to leave message on answering machine or voice mail.

☐ I approve you to leave message with person answering the phone.

This authorization will be valid until we receive further notification from you.

Patient's Signature: _____ ***Date:*** _____

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Patient Information *(cont.)*

Responsible Party Information

Name:_____

Phone: (_____) _____

Address:_____

City:_____ State: ____ Zip:_____

Relationship with Patient: _____

Responsible Person SS#: _____-_____-_____ DOB:_____ / _____ / _____

Employer's Name: _____

Phone: (_____) _____

Address:_____

City:_____ State: ____ Zip:_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductable amount, co-insurance, and other balance not paid for by your insurance company.

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

If payment is not made in full, I agree to pay all costs of collection, including attorney fees. I authorize Miami Urology & Sexual Wellness Institute to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to Miami Urology & Sexual Wellness Institute all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient's Signature: _____ ***Date:*** _____

Parent/Guardian Signature (if minor): _____