Atlantic Urology Clinics, LLC

Patient Information

Last Name:____ First Name:________________________________ MI:____________

Physical Address:____ City:________________________ St:_____ Zip:________

Mailing Address:____City:________________________ St:_____ Zip:________

Home Phone Number: ____ Cell Phone Number:______________________

Gender: ☐ Male ☐ Female SS#_____________________ Date of Birth: ___________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment Status: ☐ Full time ☐ Part Time ☐ Retired ☐ Unemployment ☐ Student

Employer/School: ____ Work Phone:______________________

May we contact you at work: ☐ YES ☐ NO

Spouse/Guarantor/Parent Information

Last Name:__________________________ First Name:_________________________ MI:________ Relationship:________ _________

Date of Birth:___________________ Employer:_________________________________ Work Phone Number:______________________

Insurance Information

Primary Insurance:____ Policy Holder Name:____________________________

Policy Holder is: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____________________ Date of Birth ___________________

Policy Number:____ Group Number:____

Secondary Insurance:____ Policy Holder Name:________________________________

Policy Holder is: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____________________ Date of Birth ____________________

Policy Number:________________________________ Group Number:_____________________________________

Emergency Contact:_____________________________ Relationship: ______________________ Emergency Phone:________________

Referring Physician:____ Phone Number:_________________________________

Family Physician:____ Phone Number: _________________________________

Pharmacy: _____________________________ Location:_____________________________ Phone Number: _______________________

Authorization for release of information and to pay insurance benefits: Atlantic Urology Clinics, LLC is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information in the future. I authorize release of medical information to my insurance carrier, their utilization management agency, my employer, or any other agency that may be assisting in payment for my care. In the event of hospitalization, I hereby assign payment to Atlantic Urology Clinics, LLC for surgical and/or medical benefits otherwise payable to me.

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Signature/Patient/Parent/Guardian Date AUC Staff Signature Date