UROLOGY ASSOCIATES OF KINGSTON IRA C. GROSSMAN, M.D. - WALTER DELGAUDIO, M.D. - MICHAEL CAMPENNI, D.O

PATIENT REGISTRATION FORM

Referred by_____ Family Physician_____

Name of Patient_____ Date of Birth_____

Address_____

_____

City, State, Zip_____

Home Phone_____ Cell Phone_____

Where may we call you for a reminder?_____

Work Number_____ May we call you at work?_____

Primary Insurance_____

Secondary Insurance_____

You may release medical records to_____

INSURANCE AUTHORIZATION

WE ARE AUTHORIZED TO FURNISH, FOR BILLING PURPOSES, INFORMATION FROM THE PATIENT'S MEDICAL RECORD TO ANY PHYSICIAN, INSURER, COMPENSATION CARRIER, OR WELFARE AGENCY WHO MAY BE PROVIDING FINANCIAL ASSISTANCE FOR CARE.

I HEREBY AUTHORIZE ANY HOLDER OF RECORDS OF MY HEALTH TO RELEASE INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL

SIGNATURE DATE

PATIENT REGISTRATION FORM

Reason for today's visit_____

Referred by_____

How long have you had these symptoms?_____

Medications:

Allergies:

Surgeries:

Hospitalizations:

Medical Illness: