GENITO-URINARY SURGEONS, INC.

1. PT. # _____ _____
LAST NAME FIRST MIDDLE INITIAL

2. PT. SS# _____ POLICY HOLDER'S SS# _____

3. PT. ADDRESS _____ ZIP _____

4. POLICY HOLDER'S ADDRESS _____ ZIP _____

5. PT. PHONE (HOME) _____ (WORK) _____ POLICY HOLDER'S PHONE _____

6. SEX: ❑ MALE ❑ FEMALE PATIENT BIRTHDAY _____

EMAIL: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

7. **REFERRING DOCTOR** _____

FAMILY DOCTOR _____

8. PRIMARY INSURANCE CO. _____

ADDRESS (BACK OF CARD) _____

POLICY HOLDER'S NAME _____ BIRTHDAY _____

CONTRACT ID# _____ SS # _____ GROUP # _____

RELATIONSHIP TO PATIENT _____

9. SECOND INSURANCE CO. _____

ADDRESS (BACK OF CARD) _____

POLICY HOLDER'S NAME _____ BIRTHDAY _____

CONTRACT ID# _____ SS # _____ GROUP # _____

RELATIONSHIP TO PATIENT _____

10. PATIENT'S EMPLOYER NAME _____ PHONE # _____

11. POLICY HOLDER'S EMPLOYER NAME _____

12. NEXT OF KIN _____ PHONE # _____

I hereby authorize the release of medical information to insurance carriers by mail, fax, or internet services concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to my dependent. I understand I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

PATIENT OR POLICY HOLDER'S SIGNATURE _____

DATE _____

(Rev. 2/08)