New Patient Information

Which Physician will you be seeing today?_____
How did you hear about our practice? _____

Local Pharmacy Name:_____Pharmacy Phone #:_____
Pharmacy Location/Address:_____

Name _____Preferred_____ Age:_____
(Last) (First) (MI)
Date of Birth:_____Sex:_____ Social Security #:_____Marital Status:_____

Race: Check one: ___ White ___Black/African American ___Asian ___American Indian/Alaska Native ___Native Hawaiian/Pacific Islander ___Other

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino Primary Language: _____

Address:_____ Home#_____
City State Zip Code
Work #:_____Cell #:_____ Preferred Communication: (Check One) ___Home ___Cell ___Work ___Email

Email Address:_____EmployerName:_____

Referring Physician:_____ Phone:_____
Primary Care Physician:_____ Phone:_____
Emergency Contact:_____ Phone:_____

Name of Spouse (or Parent if Minor):_____Spouse/ParentAddress:_____
Spouse/Parent Phone #:_____ Work:_____ Cell:_____

Spouse/Parent Date of Birth:_____Spouse/Parent Social Security#:_____
Spouse/Parent Employer:_____

Primary Insurance Company:_____ Phone:_____
Insured's SS#_____Policy Holder's Date of Birth:_____

Secondary Insurance Company:_____ Phone:_____
Insured's SS#_____Policy Holder's Date of Birth:_____

Initial Each Line and Sign Below:

_____ I authorize Lowcountry Urology Clinics, PA to release medical records to other physicians relating to my treatment and care.

_____ INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Lowcountry Urology Clinics, PA to furnish information to insurance carriers concerning my illness and treatment(s) and hereby assign to the physician all payment(s) for medical services rendered to myself or my dependents. I further understand that I am responsible for any balance not covered by insurance.

_____ I understand it is my responsibility to obtain insurance referrals from my primary care physician if required by my insurance.

_____ _____
Signature of Patient or Authorized Person Date