



Patient Information Sheet

Please print clearly
All fields required

Patient Name _____ Sex M F

Soc Security # _____ Birthday _____

Home Address (No PO Boxes) _____

City _____ State _____ Zip _____

Home Phone _____ May we leave message on answer machine? _____

Work Phone _____ May we contact you at work? _____

Cell Phone _____

Primary Doctor _____

Occupation _____ Employer _____

Responsible Party _____ Relationship _____

Spouse Name _____ Spouse DOB _____

Spouse Occupation _____ Spouse Employer _____

Spouse Work # _____ Spouse SS# _____

Emergency Contact (**not living in same house**) _____

Emergency Contact Phone # _____

Preferred Pharmacy _____

Assignment of Benefits:

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either to me or on my behalf to Cleveland Urologic Surgery, PA for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related service. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature _____ Date _____

Witness _____