Lifebridge Health/Center for Urologic Specialties

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:**
City:	**Primary Care Physician:**
State: Zip:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Email:	**Marital Status:**

SUBSCRIBER INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	**Relationship to patient:**
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State: Zip:**
Cell Phone#:	**Date of birth**
Email:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Policy#:	**Policy#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:** **Date of birth:**

PHARMACY INFORMATION

Pharmacy:	**Pharmacy Telephone:**

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Lifebridge Health, Center for Urologic Specialties when they accepts assignment.

Authorization to Release Medical Information. I hereby authorize my Provider, Lifebridge Health, Center for Urologic Specialties., to release any information necessary for my course of treatment.

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Signed (patient or parent if minor) Date