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**Patient Information**

First Name _____MI_____ Last_____

Date of Birth____/_____/_____ Social Security # _____-_____-_____ Marital Status: S W M D

Email Address_____

Preferred name if different than above_____ Race* _____Ethnicity* _____

Mailing address_____ Apt#_____

City_____State_____Zip_____

Home phone (____)_____**Cell** (_____)_____Work (_____)_____

Employer_____Occupation_____

Primary care doctor_____ Referred by (if other)_____

**Billing Statement Preference (Please circle): Email or Text Message (standard messaging rates apply)**

**Spouse Information**

First Name _____MI_____Last _____

Home phone if different than yours ( ____)_____ Cell phone ( ____)_____

**Emergency Contact (name of a friend or relative not living with you who can be reached in case of an emergency)**

Relationship to Patient _____

First Name_____ Last _____Phone# ( ____) _____

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Please indicate by circling applicable insurance coverage: **COPY OF INSURANCE CARD REQUIRED**

INSURANCE: YES NO 2ND INSURANCE: YES NO PRIVATE PAY: YES NO

Primary INS. Name: _____ Subscriber #_____Group #_____

Secondary INS. Name: _____ Subscriber #_____Group #_____

**Responsible Party for Insurance (ONLY if other than yourself)**

First Name _____MI _____Last _____

Date of Birth _____/ _____/ _____Social Security # _____-_____ -_____

Employer _____Occupation _____

Primary phone ( _____)_____ Secondary phone (_____) _____

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## AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT/CONTRACT

I hereby authorize Maui Urology ,LLC to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers of Maui Urology. I hereby agree to full responsibility for all expenses incurred by minor child or myself. I understand that a re-billing fee/finance charge complying with Hawaii State Law will be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. **Medicare: I understand that my provider may be contracted with Medicare and I agree to pay the physician for services Medicare may determine to be "non-covered" or "medically unnecessary". I understand that my provider will obtain my authorization prior to performing services, which have limited coverage under Medicare rule.

Signature _____Date _____/ _____/_____

* optional, this information is requested on some of our lab requisitions