Dr. Soren Carlsen
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Patient Information

First Name _____M_____ Last _____

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

Preferred name if different than above_____

Race (optional, requested on some of our lab requisitions) _____Ethnicity_____Gender M F O

Mailing address_____ Apt#_____

City_____State_____Zip_____

Physical Address_____Apt#_____

City_____State _____Zip_____

Mobile phone (____)_____Home phone (_____)_____Work phone (_____)_____

Employer_____Occupation _____

Primary care doctor_____ Referred by_____

Spouse Information

First Name _____MI_____Last _____

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

Employer _____Occupation _____

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

Responsible Party for Insurance (if different than above)

First Name _____MI _____Last _____

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

Employer _____Occupation _____

Primary phone (_____)_____ Secondary 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# (____) _____

Address _____City_____ State_____ Zip_____

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 #_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURA NCE 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 provider 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 is 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 _____/ _____/_____

☐ **By checking this box and typing my name below, I am electronically signing**
(for those filling out the form digitally but using a browser that does not support Adobe digital signature)

_____ Email address_____