Gulfshore UROLOGY
A Division of 21st Century Oncology, LLC

Patient Information

Date:_____
Patient Name (Last, First, MI):_____

Local Address: _____
City:_____State:_____Zip:_____

Circle One: Male Female Social Security#:_____

Birth Date:_____/_____/_____ Age:_____
LocalPhone:(_____)_____ Cellphone:(_____)_____
Northern Address:_____City:_____State:_____Zip:_____
Away Phone: (_____)_____ Email Address:_____

Patient Employer:_____Work Phone: (_____)_____
Occupation:_____
Marital Status:_____Spouse's Name:_____
EmergencyContact:_____
Responsible Party Information:
Name:_____ Phone:(_____)_____
Address:_____
City:_____State:_____Zip:_____

Relationship to Patient:_____
Responsible Person SS#:_____ Date of Birth:____/_____/_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedure, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, and other balance not paid for by your insurance company.

Method of Payment (Circle One): CASH CHECK CREDIT CARD

If payment is not made in full, I agree to pay all costs of collection, including attorney fees. I authorize Gulfshore Urology to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to Gulfshore Urology all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be as valid as the original.

Policy for Notification of Test Results

Due to new federal guidelines, the Gulfshore Urology practice has implemented a policy for notifying our patients about their test results.

Call: Home Phone#(_____)_____ Cell Phone#(_____)_____
Please check the following which apply:

- ☐ I approve you to leave a message on the answering machine or voice mail.
- ☐ I approve you to leave a message with the person answering the phone.

This authorization will be valid until we receive further notification from you.

Patient's Signature:_____ Date:_____