

## Patient Information

Chart No. \_\_\_\_\_ Goulding \_\_\_\_\_ Ploch \_\_\_\_\_ Brandli \_\_\_\_\_ Brisson \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Patient's SSN \_\_\_\_\_

Patient's Name \_\_\_\_\_  
(Last) (First) (Middle)

Patient's Address \_\_\_\_\_  
(Street or PO Box) (City) (State) (Zip)

Phone #s Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Referring and/or Family Physician \_\_\_\_\_

Patient's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

IF PATIENT IS A CHILD:

Mother \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Father \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

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Primary Insurance: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ SSN \_\_\_\_\_ \*DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ SSN \_\_\_\_\_ \*DOB: \_\_\_\_\_

*\*We must have the date of birth of the Insurance Policy Holder to file for your visits*

*\*\*\* Please attach Insurance Card(s) so we can make a copy for your records \*\*\**

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**Please note:**

Office visits, office surgeries, non-surgical treatments, and some hospital procedures are paid at the time of service unless you have contact insurance such as Medicare, BC/BS, Cigna, Companion, etc. If you are using contract insurance, you will be required to pay your co-payment and/or deductible at the time of service.

I understand that I am responsible for all charges until paid. I understand that I am responsible for obtaining prior authorization, all deductibles, co-payments, and cost shares, including deductibles and co-payments.

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Authorization: I authorize Drs. Goulding, Ploch, Brandli and Brisson of Palmetto Adult and Children's Urology, PA to release medical or other information to insurance carriers and medical professionals concerning my illness or treatments. I authorize payment of medical benefits to the physicians of Palmetto Adult and Children's Urology, PA for services rendered.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian if patient is a minor)