

**PATIENT INFORMATION**

Brisson \_\_\_\_\_ Goulding \_\_\_\_\_ Ploch \_\_\_\_\_

Chart Number \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Email \_\_\_\_\_

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

Patient's Address \_\_\_\_\_  
(Street or P.O. Box) (City) (State) (Zip Code)

Phone Numbers: 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 # \_\_\_\_\_

**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 your insurance claims.  
\*\*\* Please attach Insurance Card(s) and Driver's License so we can make a copy for your records.\*\*\**

**Please Note:**

Office visits, office surgeries, non-surgical treatments, and some hospital procedures are paid at the time of service unless you have a contract insurance such as Medicare, BC/BS, Cigna, Blue Choice, 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 deductible and co-payments.

Authorization: I authorize Drs. Goulding, Ploch and Brisson of Palmetto Adult and Children's Urology, PA to release medical 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)