Howard Leitner & Perlmutter
UROLOGIC ASSOCIATES

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Michael L. Howard, MD, FACS
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Diplomates, American Board of Urology

Registration:

Please Print
Date:_____

Patient:_____
Last Name First Name MI Suffix Degree
Responsible Party (if minor):_____
Street Address_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Home Email:_____
Work Phone:_____Ext:_____ Fax: _____
Cell Phone:: _____
Sex: ☐ Male☐Female Age:_____ Birth date: _____ ☐ Single ☐Married☐Widowed ☐Separated ☐Divorced
Social Security No._____
Which Doctor are you coming to see? ___Howard ___Leitner ___Perlmutter

Employer:_____ Employment Status_____
Business Address:_____
Occupation_____
Advance Directives Completed: ___Living Will ___Power Of Attorney ___Do Not Resuscitate
*If you have completed one of these please bring a copy with you to the office.

Primary/Emergency Contact:_____ Relationship to Patient:_____DOB:_____
Address:_____
Home Phone:_____ Cell Phone: _____
Work Phone:_____Ext:_____ Fax: _____
Business Name and Address:_____
Occupation:_____
Permission to share: ___Medical Information ___Financial Information
Who is responsible for this account? _____ Relationship to Patient:_____
Responsible Person's Social Security :_____Phone:_____

Do you have Medical Insurance? ☐ No ☐ Yes
If yes:
Primary Insurer Name:_____Phone:_____
Address:_____
Fax:_____ Policy #_____ Group #_____
Policy Holder:_____ Birth Date:_____SSN:_____
Co-Pay:_____ Deductible:_____ Expiration Date:_____

Secondary Insurer (if any): _____Phone:_____
Address:_____
Fax:_____ Policy #_____ Group #_____
Policy Holder:_____ Birth Date:_____SSN:_____
Co-Pay:_____ Deductible:_____ Expiration Date:_____
Contact #_____ Group #_____ Subscriber #_____

Registration (continued)

Primary Physician:_____ Group Name:_____
Address:_____
Phone:_____ Fax:_____
Referring Physician:_____Specialty:_____
Address:_____
Phone:_____ Fax:_____
Group Name:_____
Other Physicians you see:_____Specialty:_____
Address:_____
Phone:_____ Fax:_____
Group Name:_____

Primary Pharmacy:_____
Address:_____
Phone:_____ Fax:_____
Secondary Pharmacy:_____
Address:_____
Phone:_____ Fax:_____

How did you learn about us? ___Referring MD ___Our Website ___Other

Details: _____

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. All past due balances will be charged interest at a rate of 1.5% per month. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/ Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier

_____ _____
Beneficiary Signature Date