

PATIENT INFORMATION SHEET - PLEASE COMPLETE IN ITS ENTIRETY

LEGAL NAME - FIRST: _____ LAST: _____ MI _____

STREET: _____ SEX: F M

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: () _____

CELL: () _____ SOCIAL SECURITY: _____ DATE OF BIRTH: _____

PREFERRED LANGUAGE: _____ RACE: _____ ETHNICITY: _____

EMPLOYER: _____ JOB TITLE: _____

EMPLOYER ADDRESS: _____

WORK PHONE : () _____ MARRIED SINGLE DIVORCED WIDOWED

YOUR PRIMARY CARE PHYSICIAN: _____ PHONE : () _____

WHO REFERRED YOU TO OUR OFFICE: _____

REFERRING PHYSICIAN NAME: _____ PHONE: () _____

ADDRESS, CITY, STATE, ZIP: _____

REQUIRED TO FILL PRESCRIPTIONS

PHARMACY NAME: _____ PHONE: () _____

ADDRESS, CITY: _____ FAX: () _____

**PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE TO YOUR APPOINTMENT.
IF YOU DO NOT HAVE PROOF OF INSURANCE - PAYMENT IS REQUIRED
AT THE TIME SERVICE IS RENDERED. WE CAN MAKE NO EXCEPTIONS.**

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)

FIRST NAME: _____ LAST: _____ MI: _____

RELATIONSHIP TO PATIENT: _____ DRIVERS LICENSE #: _____

DATE OF BIRTH: _____ EMPLOYER: _____

EMERGENCY CONTACT

NAME: _____ PHONE : () _____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE INCONTINENCE & PELVIC SUPPORT INSTITUTE (IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH HIPAA REGULATIONS.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A \$5.00 MONTHLY FEE FOR BILLING SERVICE, PLUS INTEREST. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT IF MINOR) _____ DATE: _____