

SOUTH BAY UROLOGY MEDICAL GROUP, INC.
a division of USSC

FARHAD B. NOWZARI, M.D.
JOY G. PAUL, M.D.
GARRETT MATSUNAGA, M.D.

DATE: _____

PATIENT'S NAME _____ AGE _____ SEX _____
LAST FIRST MIDDLE

HOME ADDRESS _____ PHONE NO. _____
NUMBER CITY ZIP CODE

BIRTHDATE _____ SOCIAL SECURITY NO. _____ DRIVER'S LICENSE NO. _____

EMPLOYER _____ EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE _____ DEPARTMENT/OCCUPATION _____

MARITAL STATUS: M S W D SEP SPOUSE/PARENT _____

PHARMACY: Name: _____ Phone: _____ Fax: _____

RESPONSIBLE PARTY _____ DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

ADDRESS & PHONE IF OTHER THAN ABOVE _____

EMPLOYER _____ EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE _____ DEPARTMENT/OCCUPATION _____

NEAREST RELATIVE OR FRIEND _____ PHONE NO. _____

ADDRESS _____

REFERRED BY _____ FAMILY PHYSICIAN _____ PHONE NO. _____

INSURANCE INFORMATION: DO YOU HAVE INSURANCE COVERAGE? YES NO

PRIMARY INSURANCE _____

ADDRESS _____

SUBSCRIBER _____ SOCIAL SECURITY NO. _____ POL/GRP # _____

SECONDARY INSURANCE _____

ADDRESS _____

SUBSCRIBER _____ SOCIAL SECURITY NO. _____ POL/GRP # _____

OFFICE USE ONLY	UNIFIED NO. _____	BAY SHORES NO. _____	MEDI-CAL NO. _____
	THIPA NO. _____	LIFECARE NO. _____	
	ALLIANCE NO. _____	MEDICARE NO. _____	OTHER _____

TREATMENT OF MINOR: (Less than eighteen (18) years of age)

I HEREBY CONSENT TO AN EVALUATION BY SOUTH BAY UROLOGY MEDICAL GROUP, INC. FOR _____, A MINOR, AND TO ADMINISTER RECOMMENDED IN-OFFICE TREATMENTS AS DISCUSSED WITH PARENT/GUARDIAN ON THIS AND EACH SUBSEQUENT OFFICE VISIT, UNLESS CONSENT SPECIFICALLY WITHHELD AND NOTED IN CHART BY PARENT/GUARDIAN.

PARENT/GUARDIAN

ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO SOUTH BAY UROLOGY MEDICAL GROUP, INC., IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE ATTACHED CLAIM. I HEREBY AUTHORIZE THE ABOVE NAMED MEDICAL GROUP TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. YOU MAY CONTACT MY REFERENCES TO OBTAIN ADDITIONAL CREDIT INFORMATION IF NECESSARY. I REALIZE THAT I WILL BE RESPONSIBLE FOR FULL PAYMENT FOR SERVICES RENDERED AND I AGREE TO PAY ALL COLLECTION COSTS SHOULD MY ACCOUNT BECOME DELINQUENT.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____