

BROWARD UROLOGY
Elicer Kurzer, M.D., M.P.H.
Michael Simon, M.D.
700 North Hiatus Road, Suite 101
Pembroke Pines, Florida 33026
Tel (954) 499-7696 | Fax (954) 499-7699
www.browardurology.com

PLEASE PRINT CLEARLY

TODAY'S DATE: _____
LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP: _____
HOME #: _____ CELL #: _____ WORK #: _____

CAN WE LEAVE MESSAGES, RESULTS, APPT CONFIRMATION MESSAGES AT THE ABOVE NUMBERS:
PLEASE CIRCLE HOME: YES NO CELL: YES NO WORK: YES NO

SS#: _____ DOB: _____ AGE: _____ SEX: _____
MARITAL STATUS (circle one): SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

IS CONDITION: WORK-RELATED: _____ DATE OF INJURY: _____
AUTO ACCIDENT: _____ DATE OF INJURY: _____
NAME OF ATTORNEY
RERESENTING PATIENT: _____ PHONE #: _____

PRIMARY INSURANCE:

SECONDARY INSURANCE:

NAME OF INSURED: _____	NAME OF INSURED: _____
INS CO. NAME: _____	INS CO. NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____	CITY: _____ ST: _____ ZIP: _____
PHONE: _____	PHONE: _____
POLICY#: _____	POLICY#: _____
GROUP #: _____	GROUP #: _____

FINANCIAL AGREEMENT:

I AUTHORIZE THE RELEASE OF ANY PAYMENT AND MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND RELATED CLAIMS.

I ALSO UNDERSTAND THAT I AM FINCANCIALY RESPONSIBLE FOR THOSE CHARGES NOT PAID FOR BY MY INSURANCE COMPANY.

I ALSO UNDERSTAND IF THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR OUR ATTORNEY, ALL FEES WILL BE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR.

SIGNATURE: _____ DATE: _____