SCOTT D. DUDAK, MD, FACS
Urology and Urologic Surgery

9325 Glades Road, Suite 101
Boca Raton, FL 33434
Phone (561) 482-8111
Fax (561) 451-1768

Patient Information

Referred By: _____

Last Name: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other _____ Sex: ☐ Male ☐ Female

First Name: _____ Date of Birth: ____/____/_____ Age: _____ SSN: _____-_____-_____

Middle Name: _____ Preferred Name: _____ Primary Language: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or OPI ☐ White

Student Status: ☐ Full ☐ Part ☐ N/A School: _____

Employment: ☐ Full ☐ Part ☐ N/A Employer: _____ Occupation: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Email Address: _____

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____

May we leave a voice message to remind you about appointments at your home or cell phone number? ☐ Yes ☐ No

May we leave a voice message for normal test results at your home or cell phone number? ☐ Yes ☐ No

Pharmacy Name: _____ Pharmacy Phone: (____) _____

Pharmacy Address: _____

Primary Physician: _____ Primary Physician Phone: (____) _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: Home: (____) _____ Work: (____) _____

(Complete only if you want the Practice to contact you at an address/phone different than you gave above)

Other Address: _____ City: _____ State: _____ Zip: _____ Other Phone: (____) _____

Guarantor/Responsible Person (if different from patient)

Last Name: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other _____ Sex: ☐ Male ☐ Female

First Name: _____ Date of Birth: ____/____/_____ Age: _____ SSN: _____-_____-_____

Middle Name: _____ Relationship to Patient: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____

Guarantor Email Address: _____

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Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth:_____

Insurance Co. Phone Number: (____) _____

Group #: _____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth:_____

Insurance Co. Phone Number: (____) _____

Group #: _____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with the following people or organizations for the following dates of service, range of time or event(s):

From: _____/_____/_____ To: _____/_____/_____

Name (Physician, family, etc):	Address:	Phone/Fax:	Relationship:

A separate "Authorization to Release Information" form must be completed if the information being released is different for these people or organizations listed above.

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Authorization, Assignment of Benefits, and Referral Medical Release

I allow this practice to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Scott D. Dudak, MD, Notice of Privacy Practices. I have been provided a copy of the Scott D. Dudak, MD, Notice of Privacy Practices.

I allow the release of medical information, including complete medical records, test results and billing information, to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I request the following restrictions on the use of my information: _____

_____

I allow payment made directly to Scott D. Dudak, MD, for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles and noncovered services. A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge, the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient Signature: _____ Date _____/_____/_____

Print Guardian's Name:_____

Guardian Signature: _____ Date _____/_____/_____

Office Use Only:

_____

_____

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