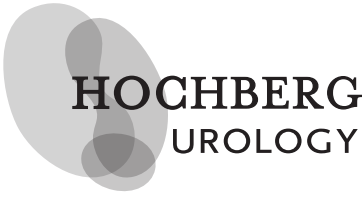


PATIENT # \_\_\_\_\_  
for office use



DAVID A. HOCHBERG, M.D.  
Diplomate American Board of Urology  
Fellow American College of Surgeons  
Practice limited to urology and genitourinary surgery

PATIENT INFORMATION RECORD

PLEASE PRINT

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Last First MI

Mailing Address: \_\_\_\_\_ Cell: \_\_\_\_\_  
HouseNumberor Apt. Number Street Name  
City State Zip Code

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Employer of Patient: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If Child, Name of Parent or Legal Guardian: \_\_\_\_\_

Employer of a Parent or Legal Guardian: \_\_\_\_\_

Work Phone: \_\_\_\_\_

If Married, Spouse Name: \_\_\_\_\_

Employer of Spouse: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name and phone number of person to contact in case of emergency: \_\_\_\_\_

INSURANCE INFORMATION

Co-Pmt: \_\_\_\_\_

1. Primary Insurance Name: \_\_\_\_\_ Gp Name: \_\_\_\_\_

Gp Number: \_\_\_\_\_

Address to Send Claims: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ SS#: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

2. Other Insurance: \_\_\_\_\_ Gp Name: \_\_\_\_\_

Address to Send Claims: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ SS#: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

If you should have more insurance policies we will gladly supply you with itemized statements to help you submit a claim.

If Workman's Compensation: Patient must have authorization prior to being seen by the physician in this office.

Date of Accident: \_\_\_\_\_ Employer: \_\_\_\_\_

Address of Carrier: \_\_\_\_\_

Name of person to contact: \_\_\_\_\_

PLEASE READ THE AUTHORIZATION AND SIGN WHERE INDICATED:

I hereby authorize my insurance company or companies listed above to make payments directly to Dr. Bernard M. Hochberg, M.D., P.A.  
I also authorize Dr. Bernard M. Hochberg, M.D., P.A. to release any information to my insurance company regarding my course  
of treatment as necessary to process insurance claims.

\_\_\_\_\_  
Signature of Patient or Legal Guardian