

New York Urology Specialists

Last Name: First Name: Middle Initial: Appointment Date:

Customer Convenience Survey

How did you hear about New York Urology Specialists? What is your reason for choosing New York Urology Specialists for your urological care? Referred by name/ source: What transportation did you use to arrive to our office: Walked Auto Bus Train Taxi Was given a ride Other: How long is your commute to our office: Did you arrive from: Home Work School Other Is our office most convenient to your: Home Work Other What are your preferred days for medical appointments: Preferred Time of the Day: Name of Preferred Hospital:

Patient Information

SS#: Address: City: State: Zip: Home Phone #: Work Phone #: Cell Phone #: Sex: Male Female Date of Birth: Email address: Employer: Employer Address: Referring MD: Referring MD Address: Primary Care Physician: Primary Care Physician Address: What other doctors do you see (Print Name, Phone # and Specialty): Marital Status: Single Married Divorced Widowed SeparatedEmployment: Full time Part time Not Employed Self Employed Retired Military DutyStudent: Full time Part time Not a Student

Spouse/ Partner/Parent/Next of Kin Information:

Name: Relationship to Patient: Address: City: State: Zip: Home Phone #: Work Phone #: Cell Phone #: Sex: Male Female Date of Birth: SS#: Employer: Employer Address: Email address:

Emergency Contact:

Home Phone #: Work Phone #: Cell Phone #: Name: Relationship to the patient:

Primary Insurance Information:

Effective Date:
 Insurance Company: Specialist Copay:
 Employer: Patient's Relationship to subscriber:
 Subscriber's Name: Subscriber's Date of Birth:
 ID#: Group #:
 Policy Phone #:

Secondary / Additional Insurance Information:

Effective Date:
 Insurance Company: Specialist Copay:
 Employer: Patient's Relationship to subscriber:
 Subscriber's Name: Subscriber's Date of Birth:
 ID#: Group #:
 Policy Phone #:

Additional Information:

Race: White Hispanic African American Asian Native American Pacific Islanders Others:
 Ethnicity: Hispanic/ Latino Not Hispanic/ Latino Other:
 Language: Preferred Contact Number:

Payment Method:

How will you be paying for services rendered? Cash Check Credit Card
 MC/VISA/Discover Number: Exp. Date:

Personal Health Info Release:

Provider can release necessary information related to my course of treatment

Patient Affirmation:

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize treatment by the physicians at New York Urology Specialists

Signature:

Date: