

**Jeffrey A. Snyder M.D., F.A.C.S.**

**Genitourinary Surgical Consultants**

Name \_\_\_\_\_ SS# \_\_\_\_\_

Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital status: S M W P D

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Alternate \_\_\_\_\_

Referred By \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Phone \_\_\_\_\_

Spouse's Employer / Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Patient Employer Information**

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patients Occupation \_\_\_\_\_

**Insured Person (If Not Patient)**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Insurance**

Primary Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Medical Information Release and Assignment of Benefits**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I hereby authorize **Jeffrey A. Snyder, M.D., F.A.C.S.** to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to **Jeffrey A. Snyder, M.D., F.A.C.S.** (or to the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

\_\_\_\_\_/\_\_\_\_\_  
Signature (patient, parent, or guardian) Relationship Date

**Miscellaneous Notes:**

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