

UROLOGY CARE OF CENTRAL FLORIDA

Paul D. Jo, MD

(352) 351-0029

2301 SE 3rd Avenue
Ocala, FL 34471

8150 SW St. Rd. 200
Ocala, FL 37781

PATIENT INFORMATION:

Last name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Mailing address if different from above: _____

Male () Female () Date of birth ____/____/____ Age ____ SS # ____-____-____

Marital status ____ M ____ S ____ W ____ D Spouse's name _____

Home phone (____) ____-____ Cell phone (____) ____-____ Other phone (____) ____-____

Nearest relative not living with you _____ Phone (____) ____-____

Employer _____ Work phone (____) ____-____

Referring physician's name _____ Phone (____) ____-____

Family physician's name _____ Phone (____) ____-____

Subscriber's name _____ Date of birth ____/____/____ SS # ____-____-____

Primary insurance _____ City/State _____

Policy # _____ Group # _____

Secondary insurance _____ City/State _____

Policy # _____ Group # _____

Authorization required Yes () No () Pharmacy name/phone number _____

**** If you have an HMO it is your responsibility to ensure that authorization has been obtained prior to your visit or procedure.**

PLEASE READ BEFORE SIGNING

I authorize payment of benefits as determined by my insurance company directly to Dr. Jo. I understand I may be responsible for any amounts not paid by my insurance company within 90 days from date of filing. I also understand filing of secondary insurance is a courtesy; if the claim is not paid within 90 days from date of filing, I will be responsible for same.

PLEASE NOTE: DEDUCTIBLES & COPAYS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature _____ Date ____/____/____ Signature _____ Date ____/____/____

Signature _____ Date ____/____/____ Signature _____ Date ____/____/____

Signature _____ Date ____/____/____ Signature _____ Date ____/____/____