

Matthew S. Lief, M.D., F.A.C.S., P.A.

Diplomate of American Board of Urology
Adult and Pediatric Urology

Primary Physician: _____ Telephone: _____

Fax: _____

Referred By: _____ Date: _____

Last Name: _____ First Name: _____

Address: _____ City and State: _____

Zip Code: _____ Date of Birth: _____ Age: _____

Home Phone #: _____ Social Security #: _____

Marital Status: Single / Married / Divorced / Widowed Drivers License: _____

Occupation: _____ Employer: _____

Work Phone #: _____ Emergency Contact: _____

Phone #: _____ Relationship: _____

Type of Insurance: _____ Policy #: _____

Secondary Ins.: _____ ID/Policy #: _____ Group #: _____

No Insurance _____ signature

Policy Holder's name if not yours: _____ DOB: _____ SS #: _____

E-mail Address: _____

Insurance Payment Certification

I authorize the assignment of medical benefits be payable to Matthew S. Lief, M.D., P.A.. I understand that I am responsible for payment of services rendered. I certify all information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize the release of any requested information to Medicare or any insurance representative, necessary to process medical claims.

LIFETIME INSURANCE SIGNATURE: _____

Medical History

Medication Allergies: _____ Reaction: _____

List Previous Surgeries: _____

Patient Signature: _____

PLEASE NOTE: WE DO NOT ACCEPT CREDIT CARDS