

**Lamia Gabal, MD**

Diplomat of the American Board  
of Urology

**Vera Trofimenko, MD**

Urologist  
Sexual Medicine Specialist

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Adult Urology

Urologic Oncology

Cystoscopy

Urodynamics

Stone Disease

Urostym

Posterior tibial nerve stimulation

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[www.drgabal.com](http://www.drgabal.com)

New Patient Packet

Dear New Patient,

Welcome to Our Practice!

We look forward to seeing you soon. If you have any questions prior to your visit, do not hesitate to call our office.

Please remember to bring:

1. Complete New Patient Packet
2. Insurance Cards
3. Referral if required by your Insurance
4. Lab results (MUST HAVE ON HAND IF APPLICABLE)
5. Radiology Testing (Reports) (MUST HAVE ON HAND IF APPLICABLE)
6. Updated Medication List (MUST HAVE ON HAND)

Please arrive 15 minutes prior to your scheduled appointment for registration.

Sincerely,

The Scheduling Staff

Prestige Medical Group

**Appointment Date:**

**MRN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PATIENT INFORMATION:**

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced  Separated

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Race:  African American  Asian  Caucasian  Hispanic  Native American  Other

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

If Patient is a child, lives with:  Both Parents  Mother  Father  Other: \_\_\_\_\_

Name of Person with Whom Child Lives: \_\_\_\_\_

**RESPONSIBLE PARTY IF OTHER THAN PATIENT**

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Responsible Party Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female Relationship: \_\_\_\_\_

**REFERRED BY:**

Referring Provider: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PCP Provider: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**IN CASE OF EMERGENCY:**

Relative/Friend: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PHARMACY INFORMATION:**

Pharmacy: (Name, Street Name & Phone, if known): \_\_\_\_\_

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but are not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Lamia L. Gabal, MD Inc. and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees **Lamia L. Gabal MD Inc. DBA Prestige Medical Group** through the services of an attorney or collection agency, I understand this will increase my balance approximately 30 percent.

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_