The Urology Center, P.C.

Date _____

PATIENT INFORMATION

Patient Name:_____
Male Female

Address: _____

_____

Home Phone: _____
Ok to leave a message Yes or No

Work Phone: _____
Ok to leave a message Yes or No

Cell Phone: _____
Ok to leave a message Yes or No

Date of Birth: _____

Social Security Number: _____

Referring Dr: _____

Family Dr: _____

Spouse/Parent: _____

RESPONSIBLE PARTY INFORMATION

Guarantor: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

_____

Employer Phone: _____

DO YOU HAVE ANY KNOW ALLERGIES?

Yes No

LIST KNOWN ALLERGIES:

_____

_____

PERMISSION TO RELEASE INFORMATION

TO: Spouse

Other: Name: _____

AMERICAN RECOVERY AND REINVESTMENT ACT, ENACTED February 2009

Preferred Language: _____

Race: ☐ American Indian or Alaska Native
☐ Black or African American
☐ Caucasian
☐ Asian
☐Native Hawaiian or Other Pacific Islander
☐Other

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Emergency Contact: _____

Emergency Phone: _____

INSURANCE INFORMATION

Primary

_____
Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

Secondary

_____
Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

The Urology Center, P.C. – Authorization Form

A. Notice of Privacy Practices

The Policies and Procedures of The Urology Center, P.C. are designed to comply with the Health Insurance Portability and Accountability Act of 1996. The Urology Center, P.C. will release your protected health information to your doctors, hospitals or insurance companies for treatment, payment and operation. The Urology Center, P.C. Notice of Privacy Practices are posted in the reception area and are available at the front desk.

B. Authorization To Treat

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving laboratory, pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

C. Assign of Insurance Benefits

I hereby assign all medical and /or surgical health insurance benefits, to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.

D. Patient Rights and Responsibilities

The Urology Center, P.C. has established a Patient's Bill of Rights, I agree that I have received and understand my rights as a patient.

E. Advance Directive

Regardless of any advance directives set forth in a living will, health care power of attorney or other written statement, any unexpected medical emergency, in this facility, will be managed with resuscitative or other stabilizing measures followed by a transfer to a hospital's emergency department.

F. Disclosure of Ownership

The Urology Center, P.C. including our Ambulatory Surgery Center, is owned and operated by Drs. Konigsberg, Kroeger, Gordon, Morton, Koukol, Longo, Lim, Jepson, Leu, Donovan and Hill. Any services that you receive at this location are a part of the operations of The Urology Center, P.C.

G. Medicare Coordination of Benefits Assessment

Medicare requires that we ask the following questions of all our patients so that we can comply with Medicare rules and regulations. We appreciate your time in completing these questions.

1. Are you or your spouse currently employed? **YES OR NO**
   If yes then:
   Do you have group health coverage based on your own or a spouse's current employment? **YES OR NO**
2. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES OR NO**
3. Is this illness or injury the result of an automobile accident or other injury? **YES OR NO**
4. Is this illness or injury the result of an accident or illness that occurred at work: **YES OR NO**
5. Has treatment and payment for this accident or illness been authorized by the Veteran's Administration? **YES OR NO**
6. Are you entitled to any benefits under the Federal Black Lung Program? **YES OR NO**

The undersigned patient or patient's guardian hereby acknowledge that I have read, understand and agree to conditions set forth in the:

A. Notice of Privacy Practices
B. Authorization to Treat
C. Assignment of Benefits
D. Patient Rights and Responsibilities
E. Advance Directive
F. Disclosure of Ownership

As a Medicare recipient, if applicable, I have completed Section G accurately and to the best of my ability.

_____ _____
Printed Patient Name Account Number

_____ _____
Signature Date

Urology Center, P.C.
Patient History Form

Date: _____ **Date of Birth: _____**

Name: _____ **Age: _____**

Past Medical History

Please check any illnesses you have or have had in the past:

___ Arthritis
___ Atrial Fibrillation
___ Asthma
___ Benign Prostatic Hypertrophy (BPH) or Enlarged Prostate
___ Bladder Infection
___ Bleeding Tendency Disorder
___ Cancer – Bladder
___ Cancer – Breast
___ Cancer – Cervical
___ Cancer – Colon
___ Cancer – Esophageal
___ Cancer – Kidney
___ Cancer - Leukemia/Lymphoma
___ Cancer – Lung
___ Cancer – Other
___ Cancer – Prostate
___ Cancer – Skin
___ Cancer – Testicular
___ Cancer – Uterine
___ Cardiac Arrhythmia
___ Chemotherapy
___ Chron's/Ulcerative Colitis
___ Congestive Heart Failure
___ COPD/Emphysema
___ Coronary Artery Disease
___ Deep Vein Thrombosis
___ Degenerative Lumbar Disk Disease
___ Dementia/Alzheimers
___ Depression
___ Diabetes
___ Dialysis
___ Diverticulitis
___ Epilepsy/Seizure Disorder
___ Fibromyalgia
___ GERD/Acid Reflux
___ Glaucoma
___ Gout
___ Heart Attack/MI
___ Hepatitis
___ Hiatal Hernia
___ High Blood Pressure/Hypertension
___ Hyperlipidemia
___ Hyperparathyroidism
___ Interstitial Cystitis
___ Irritable Bowel Syndrome
___ Kidney Infection
___ Kidney Stones
___ Liver disease/Jaundice
___ MRSA
___ Multiple Sclerosis
___ Neurogenic Bladder
___ Osteoporosis
___ Parkinson's Disease
___ Peptic Ulcer Disease
___ Prostatitis
___ Psoriasis
___ Pulmonary Embolism
___ Radiation Cystitis
___ Renal Insufficiency
___ Sleep Apnea
___ Spina Bifida or Myelomeningocele
___ STD
___ Stroke
___ Thyroid Disease
___ Transient Ischemic Attack
___ Tuberculosis
___ Urethral Stricture Disease
___ Valvular Heart Disease or Heart Murmur
___ Vascular Disease

Other:_____

Past Surgical History

Please list all of your previous operations and hospitalizations. Give dates and locations if known.

_____ _____

_____ _____

Have you had a medicated cardiac stent placed in the last 12 months? _____ If yes when? _____
If female, how many pregnancies have you had? _____ How many miscarriages? _____

Family History

Please check each medical concern that has occurred in your blood relatives:

DISEASE	Father	Mother	Sister	Brother		Father	Mother	Sister	Brother
Diabetes					High Blood Pressure				
Kidney Disease					Heart Disease				
Kidney Stones					Bedwetting				
Cancer					Nervous Disorder				
Bleeding Tendency					Stroke				
					Tuberculosis				

Is your father alive? ____Yes ____No Age/Age at death: ____ Present Health/Cause of Death _____

Is your mother alive? ____Yes ____No Age/Age at death: ____ Present Health/Cause of Death _____

If you are a male, do you have any relatives who have had prostate cancer? ___Yes ___ No

If so, which relatives? ___Father ___Brother(s) ___Other _____

If you know of any other medical conditions that run in your family, please list them here:

PLEASE COMPLETE THE QUESTIONS ON THE BACK OF THIS FORM.

Name: _____

Social Habits History

Do you smoke cigarettes? ___Yes ___No If yes, how many packs per day? ___ For how long? _____

Did you smoke cigarettes previously and quit? ___ Yes ___ No If yes, how many packs per day? ___ For how long?_____ When did you quit? _____

Do you use any other form of tobacco? ___Yes ___No If yes, what kind?_____

Do you drink alcohol? ___Yes ___ No If yes, how much do you drink in an average week? _____

Do you drink caffeine? ___Yes ___No If yes, how many per day? _____

Do you use any other drugs? ___ Yes ___No If yes, what kind?_____

Allergies

Medication	Reaction	Medication	Reaction
___Sulfa	_____	Other: _____	_____
___Penicillin	_____	Other: _____	_____
___Iodine (IV Contrast/Dye)	_____	Other: _____	_____
___Latex	_____	Other: _____	_____
Other: _____	_____	Other: _____	_____
Other: _____	_____	Other: _____	_____

Other (Please Specify): _____

No Drug Allergies _____

Medications

Please bring your current medication list to every visit to The Urology Center PC

Please list or attach a list of all the medications you are currently taking, including prescription, over the counter and herbal supplements:

Drug, medication or herbal	How often taken	Dosage (mg, mcg, IU, ect.)

Your local Pharmacy: _____

Your mail order Pharmacy: _____

Height and Weight

Height: _____ **Weight:** _____

PLEASE COMPLETE UROLOGIC SYMPTOMS ON PAGE 3

Name: _____ Date of Birth: _____

Chief Complaint

What is the main reason you came to the Urology Center at this time? _____

_____

Urologic Symptoms

Please check symptoms you have now:

___ blood in urine
___ burning or pain with urination
___ change in voiding habits
___ dysuria
___ flank pain
___ frequent urination - daytime
___ frequent urination - night
___ incomplete bladder emptying
___ incontinence
___ phimosis
___ slow urinary stream
___ stress incontinence
___ trouble starting stream
___ trouble with erections
___ urethral discharge
___ urgency
___ vaginal discharge

Review

Reviewed by: _____M.D. Date: _____