

The Urology Center, P.C.

Date: _____

PATIENT INFORMATION

Patient Name: _____
 First M.I. Last

Legal Sex: Male Female

Address: _____

Primary Phone: _____
 home cell work

Secondary Phone: _____
 home cell work

Other Phone: _____
 home cell work

Date of Birth: _____

Social Security Number: _____

E-mail: _____

Referring Dr: _____

Family Dr: _____

Preferred Pharmacy: _____

PERMISSION TO RELEASE INFORMATION

TO: Spouse Other

*If applicable, please list name(s) and phone number(s)

RESPONSIBLE PARTY INFORMATION

Guarantor Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

EMPLOYER INFORMATION

Employer Name: _____

Address: _____

Phone: _____

EMERGENCY CONTACT

Name(s): _____

Phone(s): _____

Relationship(s): _____

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

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. Kroeger, Morton, Koukol, Longo, Lim, Leu, Hill, Davies and Bishay. 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. Assign of Insurance 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 _____

The Urology Center, P.C.
Patient History Form

Date: _____

Date of Birth: _____

Name: _____

Age: _____

Chief Complaint

What is the main reason you came to The Urology Center, P.C. at this time? _____

Pharmacy

Your local Pharmacy: _____ Location: _____

Your mail order Pharmacy: _____ Address: _____

Height and Weight

Height: _____

Weight: _____

Allergies

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
___ Sulfa	_____	Other: _____	_____
___ Penicillin	_____	Other: _____	_____
___ Iodine (IV Contrast/Dye)	_____	Other: _____	_____
___ Latex	_____	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, etc.)

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:

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? _____

Advanced Directive

Do you have an Advanced Directive? Yes No

If yes, please provide a copy for The Urology Center, P.C. records.

For more information on Advanced Directives, please visit www.dhhs.ne.gov/Medicaid/Pages/ags_agsindex, or ask for a brochure at our front desk or Call NE Dept. of Health and Human Services, State Unit on Aging at 1-800-942-7830 or 1-402-471-2309

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? _____

PLEASE COMPLETE THE QUESTIONS ON PAGE 3.

Past Medical History

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

- | | | |
|--|--|---|
| <input type="checkbox"/> I do not have any significant past medical history | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Crohn's/Ulcerative Colitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Neurogenic Bladder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH) or Enlarged Prostate | <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Bleeding Tendency Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Radiation Cystitis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Cancer – Bladder | <input type="checkbox"/> Gout | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer – Kidney | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Spina Bifida or Myelomeningocele |
| <input type="checkbox"/> Cancer – Prostate | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer – Testicular | <input type="checkbox"/> High Blood Pressure or Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Urethral Stricture Disease |

Other: _____

Urologic Symptoms

Please check symptoms you have now:

- | | |
|---|--|
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> phimosis |
| <input type="checkbox"/> burning or pain with urination | <input type="checkbox"/> slow urinary stream |
| <input type="checkbox"/> change in voiding habits | <input type="checkbox"/> stress incontinence |
| <input type="checkbox"/> dysuria | <input type="checkbox"/> trouble starting stream |
| <input type="checkbox"/> flank pain | <input type="checkbox"/> trouble with erections |
| <input type="checkbox"/> frequent urination - daytime | <input type="checkbox"/> urethral discharge |
| <input type="checkbox"/> frequent urination – nighttime | <input type="checkbox"/> urgency |
| <input type="checkbox"/> incomplete bladder emptying | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> incontinence | |

Review

Reviewed by: _____ **M.D.** **Date:** _____