

**THE FOLLOWING ARE VERY IMPORTANT FOR YOU
TO BRING WITH YOU FOR YOUR APPOINTMENT:**

- All CT or XRAY film (CD format is acceptable) as well as the written report.
- Lab work including PSA reports from your referring doctor.
- Patient information forms.

REMINDER: If you have not completed your patient information forms either on-line or mailed to you, it is important to arrive 20 minutes before your appointment to complete all necessary paperwork.

Having this information, helps our doctors understand your problem without your having to come back a second time. It is possible that we may not be able to see you on your appointment day and reschedule your appointment.



Urology Consultants, Ltd.

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____
 Address: _____ City: _____ State/Zip: _____
 Home Phone: _____ Cell: _____ Marital Status: _____
 Social Security #: _____ Date of Birth: _____ Gender: _____
 Employer/Occup: _____ Employer Phone: _____
 Race: ___ Black ___ White ___ Asian ___ American Indian ___ Native Hawaiian or Other Pacific Islander ___ Other
 Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino Preferred Language: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

HEALTH INSURANCE INFORMATION – A Copy of Your Health Insurance Card(s) is Required

PRIMARY Coverage

Insurance Company: _____
 Subscriber/Card Holder/Policy Owner: _____
 Subscriber's Date of Birth: _____
 Subscriber's Relationship to Patient: _____

SECONDARY Coverage

Insurance Company: _____
 Subscriber/Card Holder/Policy Owner: _____
 Subscriber's Date of Birth: _____
 Subscriber's Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
Pharmacy Name: _____ Phone: _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding "Notice of Privacy Practices." (HIPAA)

X SIGNATURE: _____ **Date:** _____

AUTHORIZATION TO RELEASE INFORMATION (Your Signature is Required)

Do You Authorize Another Person To Receive Your Medical Information? Yes No
 If YES, Who _____ Relationship to Patient _____
 Do You Authorize Another Person To Receive Your Billing Information? Yes No
 If YES, Who _____ Relationship to Patient _____
 Do You Authorize Urology Consultants to Leave Patient Test Results on an Answering Machine or Voice Mail: Yes No If YES, at which phone number(s)? _____

X SIGNATURE: _____ **Date:** _____

Date: _____

Patient's Name: _____ Patient's Height: _____ Patient's Weight: _____

Reason For Visit/Chief Complaint: _____ Date Symptoms Began: _____

PAST SURGICAL HISTORY

Surgeries/Hospitalizations:	
1.	5.
2.	6.
3.	7.
4.	8.

Check box if list continues

Have You Ever Had A Problem With Anesthesia? No Yes:

Explain: _____

Medication/Vitamins/Supplements	Dose	Medication/Vitamins/Supplements	Dose	Medication/Vitamins/Supplements	Dose
1.		5.		9.	
2.		6.		10.	
3.		7.		11.	
4.		8.		12.	

Check box if list continues

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL/MEDICAL PROCEDURES? _____ YES _____ NO

ALLERGIES/TYPE OF REACTION

FAMILY HISTORY (Check all that apply.)

Diabetes Heart Disease Stroke High Blood Pressure
 Cancer Kidney Disease Anesthesia Problems Other _____

SOCIAL HISTORY

Tobacco Use: No Yes, Packs per day? _____ for _____ Years Stopped - When? _____
 Daily Alcohol Use: No Yes, Amount? _____ Caffeine: No Yes, Amount? _____

PAST MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
Stroke or TIA			Depression			Emphysema		
Heart Attack			Panic Attack			Asthma		
Heart Murmur			Epilepsy			Tuberculosis		
High Blood Pressure			Reflux - (GERD)			Diabetes		
High Cholesterol			Ulcers			Cancer		
DVT or Blood Clots			Hypothyroid			Type of Cancer:		
Bleeding Tendencies			Kidney Disease			Enlarged Prostate		
Anemia			Kidney Stones			HIV		
Hepatitis - What Type			COPD			Arthritis DJD		

REVIEW OF SYSTEMS

Symptom	No	Yes		No	Yes
Weight Loss			Heartburn		
Fever and/or Chills			Difficult Urination		
Double Vision			Pain or Burning on Urination		
Loss of Vision			Blood in Urine		
Loss of Hearing			Frequent Urge to Empty Bladder		
Severe Nose Bleeds			Loss of Urine when Laughing, Coughing, etc.		
Hoarseness			Weakness		
Frequent sore Throats			Frequent Itching		
Shortness of Breath with Exertion			Rashes		
Swelling of Feet or Ankles			Skin Cancer		
Sudden Changes in Rate of Heart Beat			Numbness/Tingling		
Pain or Pressure in Chest with Exertion			Seizures		
Awakened at Night Short of Breath			Memory Loss		
Asthma			Balance Problems		
Chronic Cough			Do you worry a lot?		
Coughing up Blood			Are you a nervous person?		
Frequent Chest or Bronchial Infections			Are you Frequently Unhappy or Depressed?		
Nausea or Vomiting			Excessively Thirsty, Hot, Cold, Sleepy		
Vomiting of Blood			Seasonal Allergies		
Any Change in Bowel Habits					

Doctor's Signature _____