

PATIENT HISTORY FORM

Last Name _____ First Name _____ MI _____

Appointment Date ____/____/____ Appointment Time _____ am pm

SS # _____ - _____ - _____ Date of Birth ____/____/____

Referring Doctor _____ Family Doctor _____

Pharmacy Name _____ Pharmacy Phone Number (____)____-_____

Chief Complaint (Reason for visit today – describe in detail)

List all medical problems such as diabetes, heart disease, high blood pressure, cancer, etc.

List all previous surgeries and when they occurred.

List all previous hospital admissions – when and what for

Do you smoke (if yes how much and how long)? _____

Do you drink (if yes how much and how long)? _____

Has anyone in your family been diagnosed with bladder cancer, kidney cancer, prostate cancer, kidney stones (If yes please explain)?

List any medications you are taking (including over the counter medications)

List any drug allergies and explain your allergic reaction.

At the present time do you have any problems related to the following systems?

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Weight gain/loss	Y	N

Eyes

Double Vision	Y	N
Pain	Y	N
Blurred Vision	Y	N

Ear/Nose/Throat/Mouth

Sinus Problems	Y	N
Sore Throat	Y	N
Ear Infection	Y	N

Respiratory

Shortness of Breath	Y	N
Frequent Cough	Y	N
Wheezing	Y	N

Gastrointestinal

Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N
Abdominal Pain	Y	N

Genitourinary

Urinary Frequency	Y	N
Painful Urination	Y	N
Urine Retention	Y	N

Musculoskeletal

Back Pain	Y	N
Neck Pain	Y	N
Joint Pain	Y	N

Skin

Boils	Y	N
Persistent Itching	Y	N
Rash	Y	N

Neurologic

Numbness/Tingling	Y	N
Dizzy Spells	Y	N
Tremors	Y	N

Endocrine

Tired/Sluggish	Y	N
Too hot/cold	Y	N
Excessive Thirst	Y	N

Hematologic/Lymphatic

Blood Clotting problem	Y	N
Swollen Glands	Y	N

Allergic/Immunologic

Drug Allergies	Y	N
Hay Fever	Y	N

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel depressed?	Y	N

REGIONAL UROLOGY, PLLC

First name _____ MI _____ Last name _____

DOB ____/____/____ Age _____ Sex _____

Mailing address _____

City _____ State _____ Zip _____

Phone: Home (____) ____ - ____ Work (____) ____ - ____ Cell (____) ____ - ____

Family doctor _____ Referred by _____

Employer _____ How long _____

SS number _____ - _____ - _____ Occupation _____

Spouse's full name _____ DOB ____/____/____

Spouse's SS # _____ - _____ - _____ Occupation _____

Spouse's employer _____ Work (____) ____ - ____

Emergency contact (not living in your home) _____

Address _____ Phone (____) ____ - ____

Insurance Information:

Primary insurance company _____

Policy Number _____ Group Number _____

Secondary insurance company _____

Policy Number _____ Group Number _____

(A photocopy of your insurance cards and picture ID will be made to place in your chart)

Please sign below for authorization of treatment and release of information that may be necessary for insurance purposes.

Signature: _____ Date: _____

AUTHORIZATION/RESPONSIBILITY AGREEMENT – CONSENT FOR TREATMENT

THIS IS TO CERTIFY THAT THE UNDERSIGNED AUTHORIZES THE EXAMINATION, OPERATION OR TREATMENT AS MAY BE NECESSARY OR ADVISABLE BY REGIONAL UROLOGY, P.L.L.C.

1. I, the undersigned as the patient or his/her authorized representative, do hereby authorize Regional Urology, P.L.L.C. to release to my insurance company or other appropriate agency that information which is necessary to validate this claim. Regional Urology, P.L.L.C. is also hereby authorized to release to any other physician, either as individuals or as a professional association, who perform services for me, such information as is necessary for billing purposes.
2. I hereby authorize any insurance company to pay the proceeds of any benefits due to me directly to Regional Urology, P.L.L.C. A copy of this can be considered as an original for insurance purposes. All co-pays, deductibles and out-of-pocket payments must be paid at the time of service.
3. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.
4. If this bill is not paid within a ninety (90) day period from demand or billing, Regional Urology, P.L.L.C. may turn the collection of this account over to a collection agency or an attorney. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including an/all costs of collection, attorney fees and/or court costs, if such be necessary. I wave now and forever my rights of exemption under the laws of the constitution of the State of Mississippi and any other State.
5. I, the undersigned, give Regional Urology, P.L.L.C., its employees and/or agents express prior consent to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.
6. My signature at the bottom of this page represents that I have read this agreement and understand the contents.

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PHYSICIAN

I request that payment of authorized insurance benefits be made on my behalf to Regional Urology, P.L.L.C. for services furnished to me by physicians associated with Regional Urology, P.L.L.C. I authorize Regional Urology, P.L.L.C. to release Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature as appears on insurance card

Date

REGIONAL UROLOGY, P.L.L.C.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Regional Urology, P.L.L.C. or disclosed to others for purpose of treatment, obtaining payment, or supporting day to day health care operations of the practice.

Please list below any individuals that you give permission to receive your protected health information such as family members or friends. (This page is not intended for the release of information to other physicians.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

(If more space is needed please list on the back of this page.)

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a restriction on the use or disclosure of your protected health information

Regional Urology, P.L.L.C. may or may not agree to restrict the use or disclosure of your health information. If Regional Urology, P.L.L.C. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of right to change privacy practices

Regional Urology, P.L.L.C. reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and give my permission to Regional Urology, P.L.L.C. to use and disclose my health information in accordance with it.

Printed name of patient: _____

Patient/guardian signature: _____

Date: _____