Date:_____ Urology Associates, PC Chart #_____

Patient Information:

_____ _____ _____ Male Female
Last Name First Name MI Circle One

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____
Home Phone Number Work or Cell Phone Number Martial Status: Single Married Separated Divorced Widowed N/A

_____ _____ _____
Social Security Number Date of Birth E-Mail Address

_____ _____
Occupation / Employer Spouse

_____ _____
Father's Name / Legal Guardian Mother's Name

_____ _____
Referring Doctor Dr. Phone Number

_____ _____
Primary Care Doctor Dr. Phone Number

Responsible Party: To Whom We Should Send Statements To

_____ _____ _____
Last Name First Name MI

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____
Home Phone Number Work Phone Number

Health Insurance Information: Please Provide Insurance Card

_____ _____ _____
Name of Primary Insurance Policy Identification Number Group Number

_____ _____ _____ _____ _____
Policy Holder Last Name Policy Holder First Name MI Date of Birth (required) Social Security Number

_____ Relationship: Self Spouse Parent Other
Name of Employer

_____ _____ _____
Name of Secondary Insurance Policy Identification Number Group Number

_____ _____ _____ _____ _____
Policy Holder Last Name Policy Holder First Name MI Date of Birth (required) Social Security Number

_____ Relationship: Self Spouse Parent Other
Name of Employer

Emergency Contact Information:

_____ _____ _____
Last Name First Name MI

_____ _____ _____
Home Phone Number Work Phone Number Relationship to Patient

Financial Policy for Patient Care Services

We ask that you read this policy and aid us in keeping the costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.

2. Make payment at the time of service for the entire balance if you are a self pay patient, or for the amount of any deductibles, co-pays, or past due balance that may be due.

3. Discuss your account balance only with the check-out or business staff. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any account questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the practice administrator.

I am authorizing the insurance company to pay any medical benefits for these services and all future claims to Urology Associates PC.

To help us provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 60 days.

If you have insurance and we file with your carrier, we ask that you pay ahead of time on the balance which is your responsibility according to your plan, ie. any deductibles, co-pay, co-insurance amounts. For Medicare patients, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 60 days. You are also authorizing Urology Associates, PC or it employees to release any necessary information related to this visit and all future visits for the purposes of claim(s) payment.

If you do not have insurance and are not covered by either Medicare or Medicaid, you will be considered a “SELF PAY” patient. Payment is due in full at the time of service. This assists us in cutting down on billing and operating expenses. Failure to give notice 24 hours prior to your appointment may result in a $50 fee for office appointments and $100 fee for office procedures that you have scheduled.

If we need to forward your account over to a collection agency for further legal action, you will responsible for the entire balance on your account plus any collection agency, attorney, or court fees.

_____ _____

Responsible Party or Authorized Person Signature Date

DATE: _____ **ADULT** Chart #: _____

PATIENT EVALUATION AND MANAGEMENT QUESTIONNAIRE

Welcome to Urology Associates, P.C. This questionnaire is intended to be a COMPLETE account of your medical history, and should not be limited to the lists provided. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Patient Name: _____Nickname: _____ D.O.B.: _____ Age: _____

Who is your primary care doctor? _____

For what condition are you seeing the doctor today?_____

Have you or a family member been seen here before: No Yes If yes, who _____ When: _____

MEDICAL HISTORY: Height: _____ ft _____ in Weight: _____ lbs

High Blood Pressure	Ulcers	Pneumonia/Emphysema	Thyroid Problem
Heart Attack	Kidney Stones	Diabetes	Gastric reflux
Liver Disease	Kidney Failure	Gout	Arthritis/Back Pain
Stroke/TIA	Seizures	Glaucoma	Hepatitis
Colon problems	Neuropathy	Other: _____	Other: _____

Urologic Problems _____

Cancer: Specify Type: _____

Other Medical Problems: _____

REVIEW OF SYSTEMS:

Fever	Swollen Glands	Bleed Easily	Chest Pains
Fatigue	Cough	Weight Loss	Blood in Urine
Rash/Itching	Chills	Nausea	Sweating
Diarrhea	Constipation	Vomitting	Shortness of Breath
Dizziness	Other: _____	Other: _____	Other: _____

SURGICAL HISTORY

Brain	Penis	Gall Bladder	Back	Fallopian Tubes
Lung/Chest	Kidney	Appendix	Thyroid/Neck	Vasectomy
Stomach	Hip/Knee	Ovaries	Breast	Prostate
Hernia	Nose/Sinus	Testes	Pancreas	Other: _____
Uterus	Heart	Bladder	Intestine	Other: _____

MEDICATIONS (Please list all with dose)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____
3. _____ 6. _____ 9. _____

MEDICATIONS THAT CAUSE ALLERGIES (i.e., hives, rash, difficulty breathing)

1. _____ 2. _____ 3. _____

FAMILY MEDICAL HISTORY: (Mother, Father, etc) _____

Are you allergic to iodine or seafood? Y N

Do you smoke? Y N Former (year quit _____) If yes or former: # packs per day _____ for _____years?

How many caffeinated drinks to you drink per day? _____

How many alcoholic drinks do you drink per week? _____

Reviewed by: _____