Meridian Urology & Male Infertility Clinic
Patient Information Form

Patient Information

Last Name ____________________ First ____________________ M.I. ______
Birth Date ____________________ SS # ____________________
Address ____
City ____________________ State ________ Zip ____________
Home # ____________________ Other # ____________________
Patient Employer ____________________ Work # ____________________
Spouse's First & Last Name ____
Birth Date ____________________ SS # ____________________

May We Contact You Via Email? ________ Email ____________________

Guarantor Information (This is the person financially responsible)

Name ____________________ Relation to Patient ____________________
Birth Date ____________________ SS # ____________________
Address ____
City ____________________ State ________ Zip ____________
Home # ____________________ Cellular # ____________________
Work # ____________________ Employer ____________________

Insurance Information (Insurance Card Must Be Present To Have Claim Filed)

Primary Insurance Name ____
Policy Holder Name ____
Birth Date ____________________ SS# ____________________

Secondary Insurance Name ____
Policy Holder Name ____
Birth Date ____________________ SS # ____________________

Referring Information

Who Referred You To Our Practice? ____________________

Please Read and Sign The Following

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. ***It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.***

I directly assign all medical/surgical benefits to John Greer, MD and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that photocopy of the agreement shall be as valid as the original.

____ ____________________
PATIENT SIGNATURE DATE

Meridian Urology & Male Infertility Clinic
Medical History

DATE: ____________________

NAME: ________________________________ **AGE:** ______________ **WEIGHT:** ____________

WHY ARE YOU HERE? ____

Have You Seen Another Doctor For This Problem? ______________________________

If yes, what doctor? ______________________________ **City:** ______________

FAMILY HISTORY	If Living		Age at Death	If Deceased Cause
	Age	Health		
Father				
Mother				

DO YOU HAVE A FAMILY HISTORY OF:

Prostate Cancer	Yes	No
Kidney Stones	Yes	No

HABITS:

Do You Drink Alcohol	Yes	No
Have You Ever Smoked Cigarettes	Yes	No
Avg # Packs Per Day ________	# of Years ________	
Do You Smoke Currently?	Yes	No

LIST ALL CURRENT MEDICAL PROBLEMS:

1.
2.
3.
4.
5.

LIST ALL PREVIOUS SURGERY (year & operation) :

1.
2.
3.
4.
5.

LIST ALL MEDICATION ALLERGIES:

1.
2.
3.
4.
5.

LIST ALL MEDICATIONS YOU ARE TAKING:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

____
PATIENT SIGNATURE

____
PHYSICIAN SIGNATURE

DO YOU HAVE?

Blood In Urine	Yes	No
Burning On Urination	Yes	No
Chills or Fever	Yes	No
Difficulty Urinating	Yes	No
Frequent Urination at Night	Yes	No
Leakage of Urine	Yes	No
Recurrent Kidney Infections	Yes	No
Slowed Stream	Yes	No
Problems with Erections	Yes	No

DO YOU HAVE OR HAVE YOU HAD?

Objections to Blood Transfusions	Yes	No
A-I-D-S (HIV Virus)	Yes	No
AIDs Test	Yes	No

HAVE YOU RECENTLY HAD?

Chest Pains	Yes	No
Cough or Cold	Yes	No
Extreme Tiredness or Weakness	Yes	No
Frequent Headaches	Yes	No
Indigestion, Gas or Heartburn	Yes	No
Poor Appetite	Yes	No
Swelling of Feet or Ankles	Yes	No
Unusual Thirst	Yes	No
Weight Loss	Yes	No

FOR WOMEN ONLY:
Date Of Last Period:

PHYSICIAN USE ONLY:

BENEFICIARY SIGNATURE AUTHORIZATION

I request that payment of authorized insurance benefits be made either to me or on my behalf to Meridian Urology for any services furnished to me by that physician.

I authorize any holder of medical information about me to release to the Insurance Carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

DATE: ______________________________

SIGNATURE: ______________________________