Patient Name:_____

Patient Address:_____
_____

Patient home phone #:_____

Patient Date of Birth:_____

Place of Employment:_____

Employment Address:_____
_____
_____

Employment phone number:_____

Patient Social Security Number:_____

Marital Status: Married Widowed Divorced Single

Who may we thank for referring you to our practice:_____

Emergency contact name:_____
Address:_____
Phone number:_____
Relationship to Patient:_____

PAYMENT AND HEALTHCARE OPERATIONS CONSENT FOR PURPOSES OF TREATMENT

Consent to the use of disclosure of my protected health information by DOCTORS OFFICE for the purpose of diagnosing or providing treating me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that diagnosis or treatment of myself by this DOCTORS OFFICE may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of the practice. DOCTORS OFFICE is not required to agree to the restrictions that I may request have the right to revolve this consent.

I understand that I have a right to review DOCTORS OFFICE Notice of Private Practices prior to signing this document. DOCTORS OFFICE notice of Privacy Pratices has been provided for me.

_____ _____

Patient Signature **Date of Signature**

Urology New Patient Questionnaire

As a new patient to our Urology office we would appreciate your taking a few minutes to answer the health related questions below. This information will be handled with absolute confidentiality.

1. **In your own words state the reason for today's appointment.**
   _____
   _____
   _____
   _____
2. **List all current medications**
   _____
   _____
   _____
3. **List all medical illnesses for which you were or currently receiving treatment:**
   _____
   _____
   _____
   _____
4. **List all surgeries you have had in the past (include est. dates)**
   _____
   _____
5. **List any allergies**
   _____
   _____
   _____
6. **Do you, or have you smoked? If so, how many packs and how Many years?**
   _____
   _____
   _____

7. **Do you now or have you drank alcohol in the past? If so how Often?**

   _____
   _____
   _____

8. **Describe any history of cancer, heart disease, lung disease, or kidney problems in your immediate family(mother, father, siblings, or children)**

   _____
   _____
   _____
   _____

9. **Do you currently have any of the following (if so, please circle and Describe below)**

   a. **Unexplained weight loss, fevers, chills, night sweats (yes/no)**
   b. **Dizziness, loss of balance, headaches, seizures, tremors, stroke Or other disorders of the nervous system (yes/no)**
   c. **Disorders of the eyes, ears, nose, or throat (yes/no)**
   d. **Is your hearing sufficient for hearing at standard spoken volumes (yes/no)**
   e. **Anxiety, depression or any psychological or emotional condition (yes/no)**
   f. **Persistent shortness of breath, hoarseness, persistent cough or other lung disorder (yes/no)**
   g. **Chest pain, irregular heart beat, heart murmur, heart attack or other disorder of the heart or blood vessels (yes/no)**
   h. **Difficulties with sexual function (yes/no)**
   i. **Changes or difficulty with menstruation (yes/no)**
   j. **Are you pregnant (yes/no) Date of last menstrual period**
   k. **Arthritis, gout, chronic back pain (yes/no)**
   l. **Disorders of the skin or new skin lesion (yes/no)**
   m. **Bleeding tendancy (yes/no)**

Signature_____

Physicians Signature_____

INSURANCE INFORMATION

NAME: _____
ADDRESS:_____
_____
PHONE: _____
DOB:_____ SSN#_____

REFERRING DOCTOR:_____

PRIMARY
INSURANCE:_____

POLICY #_____
GROUP # _____

SUBSCRIBER:_____
SUBSCRIBERS DOB:_____

SECONDARY
INSURANCE:_____

POLICY#:_____
GROUP#”_____