Main Urology Associates, P.C.
Brompton Professional Park
6645 Main Street
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--Practice Limited to Urology*Office Hours by Appointment--

Appt. Date:

Location:

WELCOME TO MAIN UROLOGY

Thank you for calling our office for an appointment. In order to serve you more efficiently on the day of your appointment we ask that you:

1) Fill out the enclosed patient information forms.

2) Bring the completed forms with you on your appointment date.

3) Bring your insurance cards. If your insurance requires a referral, you must have it on the day of your appointment, or your appointment will be rescheduled.

4) Be prepared to pay a copay if your insurance so requires

5) Failure to complete the patient information forms will cause a delay in your appointment time.

We are looking forward to participating in your good health.

Sincerely,

Physicians & Staff
of Main Urology

Main Urology Associates, P.C.

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Account No. ____________

PATIENT INFORMATION

Name ______________________ Date of Birth ____________

Address ______________________

City, State, Zip ______________________ Phone ____________

Sex ______ Marital Status ______ Race ______ Soc. Sec. No. ____________

Referring MD ______________________ Family MD ____________

Employer Name, Address and Telephone ______________________

____

Emergency Notification

Name ______________________ Relation to patient ____________

Telephone Work ______________________ Home ____________

Type of Insurance ______________________ ID# ____________

Policy Holder ______________________

Place of Employment of Insured ______________________

____

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, significant other, a parent or sibling, or any other individual, you must indicate the name of that specific person(s). WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.

I, ______________________, hereby give my permission for the staff of
(Your Name)

Main Urology Associates to release medical information about myself to:

____
(Name of person you are authorizing) (Relationship)

____
(Name of person you are authorizing) (Relationship)

I may cancel this authorization at any time by written notification.

Signature ______________________ Date Signed ____________

REV. 4/03

PATIENT HISTORY

The reason you are seeing the doctor today: ____________________

Allergies: None List: ____________________

Medications (including over-the-counter): ____________________

____

Pharmacy name and telephone #: ____________________

Personal Medical History (please circle any of the following which you have):

AIDS	Epilepsy	Kidney Stones
Angina	Emphysema	Meningitis
Anemia	Genital Herpes	Peptic Ulcer
Arthritis	Glaucoma	Pneumonia
Asthma	Heart Disease	Radiation Therapy
Cancer	Heart Murmur	Sickle Cell Disease
Cataracts	Heart Valve Replacement	Sinus Pain
Chemotherapy	Hemophilia	Stroke
Depression/Anxiety	Hepatitis	Thyroid Disease
Diabetes	High Blood Pressure	Tuberculosis
Diverticulosis	Joint Replacement (hip/knee)	Venereal Disease

Other: ____________________

Do you wear glasses or contacts? Yes No

Are you hard of hearing? Yes No

Do you smoke? Yes No #PPD______ #Y ears______

Do you drink alcohol? Yes No Occasionally Rarely

Do you take antibiotics before dental work? Yes No

Women: Are you pregnant? Yes No #Weeks______
Date of last PAP Smear:________________

Men: Family history of prostate cancer? Yes No
Sexual function: Difficulty obtaining erection, difficulty maintaining erection, erection inadequate for intercourse?

List all past surgery with approximate date or age: ____________________

____

Patient's Name:____________________ PT#: ____________ D.O.B. ____________

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