❑ Fairfax
❑ Fredriksson
❑ Greer
❑ King
❑ Klein

❑ Miller
❑ Rice
❑ Waldmann
❑ Williams

❑ Allen
❑ DeMasters

IDAHO UROLOGIC INSTITUTE

SURGERY CENTER OF IDAHO

Account # _____

Date _____

Patient's Legal Name: Last _____ First _____ Middle _____ ❑ Male ❑ Female

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell / Pager _____ Age _____ D.O.B. _____ Marital Status M ❑ S ❑ D ❑ W ❑

Patient's Employer _____ Work Phone _____ Ext. _____

Occupation (or none, student, homemaker, retired) _____ S.S.# _____

Spouse's Name _____ D.O.B. _____ Employer _____

Spouse's S.S.# _____ Work Phone _____ Occupation _____

Can we contact you by email: ❑ Yes ❑ No Personal email: _____ Work email: _____

Patient's legal guardian _____

Father's Name (IF MINOR) _____ S.S.# _____ D.O.B. _____

Father's Home Address _____ City, State, Zip _____ Phone _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Name _____ S.S.# _____ D.O.B. _____

Mother's Home Address _____ City, State, Zip _____ Phone _____

Mother's Employer _____ Occupation _____ Work Phone _____

Whom May We Contact in Case of Emergency? _____

Relationship _____ Phone _____

Who referred you to our Practice? ❑ Yellow Pages ❑ Newspaper ❑ Radio ❑ Family/Friend ❑ E/R ❑ Physician: (Please note below)

Primary Care Physician _____ Date Last Seen _____ Referring Physician _____ Date Last Seen _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____

Insurance Co. Address _____

Subscriber Name _____ Relationship to Subscriber Self ❑ Spouse ❑ Parent ❑ Child ❑ Step Parent ❑ Other ❑

Group No. _____ I.D. No. _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____

Insurance Co. Address _____

Subscriber Name _____ Relationship to Subscriber Self ❑ Spouse ❑ Parent ❑ Child ❑ Step Parent ❑ Other ❑

Group No. _____ I.D. No. _____

Date of last Lab Work _____ , X-Ray _____ , CT Scan _____ , MRI _____

Location _____

Please remember that 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 for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to Idaho Urologic Institute, P.A. and Surgery Center of Idaho and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Idaho Urologic Institute, P.A. and Surgery Center of Idaho to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign here: _____ Date _____

I, the undersigned acknowledge receipt of a copy of Idaho Urologic Institute, P.A. and Surgery Center of Idaho Notice of Privacy Practice. A copy will be available at our office.

Sign here: _____ Date _____

IDAHO UROLOGIC INSTITUTE

HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____ Age: ____ Primary Care Physician: _____

Reason for visit: _____

When did symptoms first occur? _____

Have you seen another Physician for this problem? ____ Who? _____ When? _____

Do you have allergies to foods or medications? Please list, including reaction.

Food or Medication	Reaction

Please list current medications:

Medication	Dosage	Prescribing MD

Please list all times you have been admitted to the hospital for illness or surgery.

Year	Illness or Surgery	Physician

When was your last physical exam? _____

YOUR PAST HEALTH HISTORY

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when the illness started, write down the approximate year.

(X)	Illness	Year
❑	Asthma	
❑	Emphysema	
❑	Chronic Disease(s)	
❑	Phlebitis	
❑	Stomach or Duodenal Ulcer	
❑	Hepatitis	
❑	Rectal Problems	
❑	Diabetes	
❑	Arthritis	
❑	Seizures	
❑	Smoke or chew tobacco	

Packs per day _____
Age started _____
Age quit _____

(X)	Illness	Year
❑	Urinary Problems	
❑	Prostate Problems	
❑	Kidney Stones	
❑	Breast Problems	
❑	Heart Problems	
❑	Heart Valves	
❑	High Blood Pressure	
❑	Angina	
❑	Thyroid Problems	
❑	Kidney Problems	
❑	Hemorrhoids	
❑	Abnormal Lumps	
❑	Cancer	

Type: _____

❑ Drink Alcohol
How often? _____
How much? _____

YOUR FAMILY'S HEALTH HISTORY - Information needed on immediate family only.

Relationship	Age, if living	Age at death	State of health or cause of death (Example: Cancer, Diabetes, Heart Disease)
Father			
Mother			
Brother(s)			
Sister(s)			

IDAHO UROLOGIC INSTITUTE

Today's Date _____

HEALTH HISTORY QUESTIONNAIRE continued

REVIEW OF SYMPTOMS

PATIENT NAME: _____

DATE OF BIRTH: _____

GENERAL

Yes	No	
❑	❑	feel tired, worn out
❑	❑	had chills, fevers, sweats
❑	❑	lost or gained weight

Weight now _____

Normal weight _____

SKIN

Yes	No	
❑	❑	skin rashes or itching
❑	❑	changes in hair or nails
❑	❑	skin changed color

EYES

Yes	No	
❑	❑	pain in your eyes
❑	❑	blurry vision
❑	❑	change in vision
❑	❑	glaucoma
❑	❑	halos around lights

EARS/NOSE/THROAT

Yes	No	
❑	❑	trouble hearing, pain
❑	❑	lump in throat
❑	❑	drainage in back of throat
❑	❑	ringing/buzzing in ears
❑	❑	sore tongue, mouth and /or throat

RESPIRATORY

Yes	No	
❑	❑	persistent cough
❑	❑	difficulty breathing

CARDIOVASCULAR

Yes	No	
❑	❑	pain/pressure in chest
❑	❑	swelling in feet or ankles
❑	❑	awaken short of breath
❑	❑	irregular or rapid heart
❑	❑	short of breath with exertion
❑	❑	sleep with head up

GENITOURINARY

Yes	No	
❑	❑	incontinence of urine
❑	❑	burning, painful urination
❑	❑	frequent urination
❑	❑	trouble passing urine
❑	❑	passed blood in urine

WOMEN ONLY

Yes	No	
❑	❑	menstrual periods abnormal
❑	❑	lumps in breasts
❑	❑	passed menopause/change

Number of pregnancies: _____

Number of children _____

Age at first pregnancy _____

BE SURE TO TELL US IF YOU ARE PREGNANT OR BECOME PREGNANT DURING OUR EVALUATION OR TREATMENT.

GASTROINTESTINAL

Yes	No	
❑	❑	difficulty swallowing
❑	❑	red rectal bleeding
❑	❑	black stools
❑	❑	diarrhea
❑	❑	constipation
❑	❑	recent change in bowels
❑	❑	abdominal pain
❑	❑	nausea/vomiting
❑	❑	change in eating habits
❑	❑	indigestion, bloating, gas
❑	❑	specific food intolerance

Please specify food: _____

MUSCULOSKELETAL

Yes	No	
❑	❑	trouble with hip joints
❑	❑	joint pain or stiffness
❑	❑	difficulty walking
❑	❑	back pain

NERVOUS SYSTEM

Yes	No	
❑	❑	frequent headaches
❑	❑	memory loss
❑	❑	tingling arms, legs
❑	❑	poor coordination/balance
❑	❑	dizziness, fainting spells
❑	❑	convulsion, seizure
❑	❑	weakness in arm/leg

PSYCHIATRIC

Yes	No	
❑	❑	depression
❑	❑	extreme mood swings
❑	❑	nervous breakdowns
❑	❑	sleep disturbances

ENDOCRINE

Yes	No	
❑	❑	weakness
❑	❑	excessive thirst
❑	❑	feel too hot, too cold

HEMATOLOGIC/LYMPHATIC

Yes	No	
❑	❑	Do you have swollen glands?
❑	❑	Do you bleed easily?

ALLERGY/IMMUNOLOGIC

Yes	No	
❑	❑	hives
❑	❑	hay fever

LIST ANY OTHER SYMPTOMS THAT YOU THINK MIGHT BE IMPORTANT.

IDAHO
UROLOGIC
INSTITUTE

PATIENT FINANCIAL POLICY

(Please read carefully!)

SURGERY CENTER OF IDAHO

Welcome to our practice! Thank you for choosing us as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions regarding this policy, please discuss them with our Business Office Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care.

- Your health insurance policy is a contract between you and your insurance company. In many instances, the doctor is not involved. It is your responsibility to know the specifics of your insurance coverage and benefits.

- We have made prior arrangements with some health care plans to accept an assignment of benefits. Please call your insurance company prior to your appointment to determine if your physician is a participant in your plan. We will submit a claim to those plans for which we have a contractual agreement and will require you to pay your authorized co-payment at the time of service. We will collect all co-payments and deductibles as soon as you arrive for your appointment. We accept checks, money orders, VISA, MasterCard, or cash. We do not accept debit cards. It is your responsibility to be prepared to make your co-payment when you check in. If you are not able to make your co-payment, you will be asked to reschedule your appointment to a time when you are able to do so.

- If you have a health care plan that we do not have a contracting agreement with, we will prepare the claim for you on an unassigned basis. In this instance, our charges for your care and treatment for your initial visit will be due at the time of the service. We must emphasize that as Medical Care Providers, our relationship is with you, not with insurance companies, and insurance companies may calculate their re-imbursement rates to you in a manner that may not fully cover your charges. It is important that you understand your health insurance policy and the coverage it provides.

- Please bring a current copy of your insurance card and current referral if required by your insurance at the time of your visit. Medicaid/Healthy Connections patients are required to bring a current copy of their card or if application is in progress, documentation from Medicaid that this will be a covered service. Healthy Connections patients also will need to bring their Healthy Connections referral or make arrangements to have it sent or faxed to our office from their Primary Care Physician **prior** to their visit. If proof of insurance is not provided, you will be expected to make payment in full at time of service.

- Please advise us of any change in address, phone number, or insurance that may occur.

*For the following items, please indicate that you understand by **printing your initials:***

_____ In order to provide the best possible service and availability to all our patients, please call **as soon as possible** if you know you will need to reschedule your appointment.

_____ Not all health plans are the same nor do they all cover the same services and supplies. In the event that your health plan determines a service or supply to be **"not covered"**, you will be responsible for the complete charge for that particular service. Payment is due upon receipt of a statement from our billing office. If you need to make arrangements for a payment plan, please contact our Business Office. Payment for certain supplies will be required at the time of the visit (e.g., catheters, leg bags, lubricants, etc.).

_____ You will be charged for the processing of forms (e.g., disability forms, life insurance info, etc.) at $15 to $30 (depending on the length of the forms), or for copying/faxing/mailing medical records (75 cents per page, plus postage). In most instances, your insurer does not cover these charges.

_____ There will be a $25.00 charge for insufficient fund checks issued.

I have read and understand the financial policy of the Idaho Urologic Institute P.A. and/or Surgery Center of Idaho and agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

_____ _____

Signature ***Date***

_____

Print