EFFINGHAM UROLOGY ASSOCIATES SC
Patient Information Sheet

Date:	Chart #:	Referring Physician:	Age:
Patient Name:			Marital Status:
Mailing Address:		City:	State:	Zip:
Home Phone:		Birthdate:	SS #:
Parents (if pt is a minor):			
Is Child Covered under Parents Insurance?		Is there any Secondary Insurance?	

Employer Information			
Employer:			Employer Phone:
Employer Address:	City:	State:	Zip:

Spouse Information			
Name:		Address:	
SS #:	Birthdate:	Employer:	
Employer Address:			Phone:
*In Case of Emergency Contact:			Phone:

Insurance Information:
Do you have Medicare? _____
On the job Injury? _____
(If yes, complete worker's comp form)

Do you have Medicaid? _____
Motor Vehicle Accident? _____
(If yes, complete MVA form)

Insurance Co.:			Insurance Co.:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Policyholder:			Policyholder:		
Policy #:			Policy #:		
ID #:			ID #:		

Do we have permission to release medical information to family members? _____ (Specify)

I understand that my primary insurance will be filed, and if no payment is made within 45 days, I will be responsible for the balance.

I hereby authorize Effingham Urology as a holder of Medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claims(s). If further request payment be made to Effingham Urology and authorize the Center to submit claims on my behalf for a bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my inusrance carrier. If this accouunt is placed in the hands of collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

PERMISSION TO TREAT: I hereby give Effingham Urology permission to evaluate and treat the above named patient.

_____ _____
Date Signature of Patient, or if Minor, parent/guardian

P.D.L. NAYAK, M.D.

NAME: _____ DATE: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems?

Circle Yes or No. Please explain any YES answers in the space provided.

EYES

Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

EAR/NOSE/THROAT/MOUTH

Ear infection Y N
Sore throat Y N
Sinus problems Y N
Other _____

NEUROLOGICAL

Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

RESPIRATORY

Wheezing Y N
Frequent Cough Y N
Shortness of breath Y N
Other _____

ENDOCRINE

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

HEMATOLOGIC/LYMPHATIC

Swollen glands Y N
Blood clotting problem Y N
Other _____

GATROINTESTINAL

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

PSYCHOLOGIC

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other _____

INTEGUMENTARY

Skin rash Y N
Boils Y N
Persistent itch Y N
Other _____

MUSCULOSKELETAL

Joint pain Y N
Neck pain Y N
Back pain Y N
Other _____

Physician: _____ Date: ____/____/____