Registration Form

Steven K. Sterzer, M.D., Inc.

Date_____

Patient's Full Name_____
Mailing Address_____
Physical Address_____
Phone_____
Date of Birth_____ Age_____ Sex_____
Soc. Sec. #_____ Driver's Lic. #_____

***If patient is a minor, please fill in the following information.
Parent/Guardian_____ Relation_____
Addr/Phone (if different than patient)_____
Parent/Guardian_____ Relation_____
Addr/Phone (if different than patient)_____

***Patients, please fill in the information below. If the patient is a minor, please fill in the information of the responsible party.
___Married ___Single ___Widowed ___Divorced ___Separated
Occupation_____ Employer_____
Employer's Addr_____

Spouse_____ Work Phone_____
Emergency Contact_____ Phone_____

Insurance_____ Subscriber_____
ID#_____ Group#_____
Subscriber's employer, if different than patient_____

Reason for visit_____
Referred by_____ Family Physician_____
Pharmacy of choice_____

Are you willing to accept blood products if the need ever arises?_____

WE WILL BILL YOUR INSURANCE
PLEASE PRESENT INSURANCE CARD(S) AND CO-PAY AT TIME OF VISIT

Insurance Information: Though we bill insurance, it is the responsibility of the patient/responsible party to know what his or her own policy will provide. We encourage patients to discuss fees with us prior to any major medical or surgical procedure, and to call their insurance companies to verify coverage.

Assigment of Benefits: I hereby authorize payment directly to **Steven K. Sterzer, M.D., Inc.** of the insurance's surgical and/or medical benefits otherwise payable to me for their services. I accept personal responsibility for payment of charges for services rendered to me and I understand that full payment is due within 60 days unless other arrangements have been made. A service charge of 18% will be added to all overdue accounts.

Late Cancellations: I understand that it is my responsibility to pay a $15 fee for any appointment canceled with less than 24 hours advance notice.

Patient's Signature_____
OR Responsible Party_____ Relation_____

HISTORY AND PHYSICAL

Name:_____ Age:_____
Referred By:_____ Date:_____
Have you ever been seen previously in this office? YES NO If yes, when?_____

***Please answer all questions. If the question does not apply to you, please write "n/a."

YES NO Pain or burning with urination?

YES NO Painful bladder?

YES NO Double voiding? (Need to void within 5 minutes of last void)

YES NO Post-void dribbling?

YES NO Blood in urine at any time?

YES NO Slow urinary stream?

YES NO Difficulty starting urination?

YES NO Inability to hold urine (wet pants)?

YES NO Bedwetting?

YES NO Kidney infections?

YES NO Bladder infections?

YES NO Recent fever or chills?

YES NO Urinating too frequently (more than 6 times a day)?

YES NO Awakening to urinate more than once in a night?

YES NO Have you ever been to a Urologist before?

YES NO Have you had kidney or bladder X-rays before?

YES NO Have you had any Sexually Transmitted Diseases (STDs)?

YES NO Have you had any prostate infections (prostatitis)?

YES NO Any difficulties with erections?

YES NO Discharge from penis?

***More questions on backside.

List prior illnesses or injuries and the year they occurred:

List prior surgeries and the year:

List all medicines you are ALLERGIC to:

Do you smoke? YES NO Have you smoked? YES NO Year you quit?_____
Packs per day?_____ Number of years you've smoked?_____

Do you drink alcohol? YES NO Drinks per day?_____

Do you take aspirin or any other blood-thinning products? YES NO
If yes, please specify what you take:_____

List all medicines and dosages you are currently taking:

Has anyone in your family had?... (circle) Cancer Tuberculosis Diabetes

Heart Disease High Blood Pressure Kidney Failure Kidney Stones

Age and health problems of: Mother_____ Father_____

Sister_____ Brother_____

Do you have problems with?... (circle all that apply)

Weight gain/loss Dizziness Appetite Fever Tiredness Insomnia Headache

Vision Hearing Nose Voice Swallowing Throat Chest Pain Breathing

Palpitations High Blood Pressure Stomach Aches Constipation Diarrhea

Bloody Stools Walking Weakness Arthritis Swelling of Limbs Strokes

Seizures Diabetes Bruising Bleeding

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*Women only, please answer the following:
YES NO Are your periods normal? If not, describe.
YES NO Have you had surgery on your uterus or ovaries? When?
YES NO Have you had bladder surgery? When?
If applicable, when was your last period?_____
Number of pregnancies?____ Number of births?____ Miscarriages/Abortions?____