

PLEASE PRINT

PATIENT REGISTRATION

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Name: _____ **Date of Birth** _____

Address: _____ **Social Security #** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Address _____ **City:** _____ **State** _____ **Zip** _____

Marital Status: (circle one) Single Married Widow Divorced

Nearest Friend/Relative Not Living With You: _____

How related: _____ Home Phone: _____ Work/Cell Phone: _____

Referral Source: Friend/Family Yellow Pages Physician Name & Phone # _____
(First and Last Name)

Family Doctor: _____
(Name, City, State & Phone Number)

Pharmacy Name _____ **Pharmacy Phone Number** _____

Bill To Information: (Complete only if you are NOT the responsible party)

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Employer _____ Work Phone # _____

PRIMARY INSURANCE

Name of Primary Insured: _____

Social Security # _____

Ins. Company _____

Policy # _____ DOB _____

Group # _____ Employer _____

SECONDARY INSURANCE

Name of Secondary Insured: _____

Social Security # _____

Ins. Company _____

Policy # _____ DOB _____

Group # _____ Employer _____

ASSIGNMENT OF BENEFITS, NOTICE OF PRIVACY AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request that payment of authorized benefits (Medicare and/or those from above listed insurance company) be made either to me or on my behalf to Urology Associates for any services furnished to me by that physician/supplier. I authorize any holder to medical information about me to release to the Division of Family Services, the Health Care Financing Administration, the above listed insurer, and/or agents of these companies any information needed to determine these benefits or the benefits payable to other related services. Upon request I may receive a copy of Urology Associates Notice of Privacy.

BILLING PARTY RESPONSIBILITY

I understand that I am financially responsible for all charges regardless of insurance coverage. Should this account become delinquent, the undersigned agrees to pay all of creditor's collection expenses, including all collection agency fees and all attorney fees. If suit is brought, it may be filed in the county where services were rendered..

X _____
Patient Signature

Date

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

Social Security No. _____ DATE OF BIRTH ____/____/____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

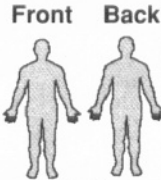
History of Present Illness

Please answer the following questions

Location of the problem

Abdomen Back Leg

Other _____



How long does the problem last?

30 minutes 1 hour It is always there
 Other _____

Is anything else occurring at the same time?

Yes No If yes, please explain.
 Nausea Rash Headaches
 Other _____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there
 Other _____

Does the problem interfere with your normal functions?

Yes No If yes, please explain _____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other _____

Physician use only: (Comments/Notes)

Hesitancy	Frequency
Intermittency	Urgency
Decreased FOS	Urge Incont
Incomp Empty	Dysuria
Double Void	Hematuria
Stress Incont	Nocturia
(pads/day)	Happy w/ void

Hx Stones	Impotence
Hx UTI's	Gait
Constipation	LBP/Sciatica

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery _____ Date _____

Are you on any medications? Y N (If yes, list all.)

Are you on a special diet? Y N (If yes, please explain)

Do you have allergies? Y N (If yes, Please explain.)

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5



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 space provided

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Other _____

Eyes

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

Allergic/Immunologic

Hay Fever Y N
 Drug allergies Y N
 Other _____

Neurological

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

Endocrine

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

Gastrointestinal

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

Cardiovascular

Chest pain Y N
 Varicose veins Y N
 High blood pressure 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 _____

Ear/Nose/Throat/Mouth

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

Genitourinary

Urine retention Y N
 Painful urination Y N
 Urinary frequency Y N
 Other _____

Respiratory

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

Hematologic/Lymphatic

Swollen glands Y N
 Blood clotting problem 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 _____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____

Date: ____ / ____ / ____

Urology Associates Of Central Missouri

PERMISSION TO SHARE MEDICAL INFORMATION

Due to Government privacy regulations we are not allowed to discuss any medical information or treatment regarding you with any of your family members or friends unless we have written consent from you. Please list your family member or friends below whom we may discuss your medical information. This list might consist of your spouse, children or friend.

I _____ give permission for Urology Associates to
(patient's printed name)

discuss my medical treatment with the following persons:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient's Signature

Date